# 240 Something machines can’t do

In line with the current Advanced Emergency Nursing Blog (Automated Vital Signs – Who’s the automaton?), here are some things that your VS machine can’t do, but are useful to you.

A conventional aneroid sphygmomanometer can help you start a difficult IV. Very often, the problem in finding a vein is due to an inadequate tourniquet, inadequate filling of the limb, or poor blood pressure. When there’s no time for hot towels or heel-warmers, invert the cuff on the arm (tubing running straight to the gauge without kinking) so as to leave the entire lower arm free of interference. Inflate the cuff to a pressure between the diastolic and the systolic. Lower the limb below the table or trolley. The cuff (wider and more comfortable) gives better compression and sequestration of venous return, especially in shocky patients (e.g. BP = 46/40; {true case}).

I’ve previously reported using a stethoscope to assess for leg fractures. There is some updating of that in “Tuning fork ultrasound.” Useful for austere conditions and suggested for occult fracture screening. The study has an ‘n’ of 20 but with MRI control; decrease in amplitude was noted with 80% accuracy.

And, of course, a machine can’t swing a stethoscope head as a substitute reflex hammer.

# 241 Masking Communication in La Gripee of Influenza

This is a hard season of Influenza with possibly harder conditions to follow. It seems that many staff are continuously wearing masks throughout their shifts. Whether this is because they are unvaccinated (I hope not.) or are vaccinated (I hope so.) and are protecting themselves because of the less-than-desired efficacy of the vaccine, remains a barrier to communication as well as to droplets.
Many cultures pride themselves upon open-faced communications and community. To be open-faced is a synonym for forthright honesty. We look to the animation of expression and clarity of speech, for intimations of perceived character and honest interaction. Being masked in public seems as if there is something to hide, and ordinances often prohibit it.

What is known to be true is that concealing the mouth, and much of the face, deprives the listener of non-verbal clues to speech articulation and nuances of mood upon which we rely more than we think about it. This is worse if task fixation averts gaze so that the eyes are unread, and a somewhat muffled voice is directed away. Think of dramatic operating room scenes in movies or TV, where everything is controlled in an ideal way, yet some quality of communication is lost.

Remind all staff of these things, and how extra measures must be made by them, to ensure clarity.
1. Engage the patient directly with the eyes, as much as possible.
2. Use a *slightly* louder and more crisp articulation of speech.
3. Discern if possible, even by direct question, of any deficits the patient may have in hearing, seeing, speaking, translation, medical literacy, that will impair interaction.
4. Say to them that masks can make it harder to understand and that it's OK to ask for a repeat or explanation.
5. Draw out feedback that one is clearly understood despite the mask.
6. Assure the other person the mask is used, not from fear, or that the patient is dangerous, but is a neutral protection for everyone in minimizing transmission of disease.

(As one who is required to use a Powered Air Purifying Respirator due to glasses and beard, I am very conscious of people’s reaction to it, reminiscent of epidemic thrillers and biological warfare, and must assure them that it is just the safety equipment that I am required to wear.)

If a PAPR *is* worn, be aware of the optical and auditory impairment (wild sound from the motor), limited field of vision and difficulty with fine vision or charting, and how some head movements can displace the position of the mask. Battery life, and spare charged battery is critical. Spare headgear is important if there is contamination or scratching of the plastic view plate. Auscultation can be worsened by the additional noise.

# 242 Three "Cs" of Procedural Sedation and Analgesia

When we, as health professionals, must ourselves must be a patient, we can usually compose ourselves with equanimity due to our knowledge base, comprehension, and rationality. This is not always true for our unprepared patients, stricken with sudden injury, and very real emotional responses (which, in ourselves, we choose not to admit). In pre-op areas,

I've (so far) been able to forego 'pre-meds' intended to tranquilize the anxious. My mantra has been that I am "Comfortable, Calm, and Confident." To my thinking, these three spheres, as in a Venn diagram, comprise the elements of mental/emotional preparation/resuscitation before significant procedures, to which assessment and attention need to be paid before beginning.
Many emergency clinicians most want reliability and pragmatically choose a good dose of Propofol rather than "woo-woo" stuff, such as hypnosis that take time and have variability. Strength in chemicals, as it were, rather than engagement in feelings. Yet the unprepared mind may need more chemicals than it otherwise might, and agitation during induction or emergence may be fear-based apart from pharmacology.

The upshot of the chemical approach is that often, for something that is painful, 'sedated' procedures are not really 'conscious' sedation, 'moderate' sedation, but "brief general anesthetics without paralysis". There, it's said; —what couldn't be said for legal and billing reasons. If it weren't for prowess at airway management and resuscitation, and attention to guidelines, there might have been some unfortunate incidents.

This doesn't mean that attending to the three C's removes all risk, but one may be able to use less sedation, or help someone through a moment with an encouraging word, rather than another bolus.

- **Comfortable**: Ease pain. Good local or regional block. Warmth. Positioning. Family concerns met. Assurance of less or controllable pain afterwards. The patient should seem 'snug'.

- **Calm**: Anxieties addressed. Teaching done. Expectations explained. "And, when you wake, the cast will hold the bones steady so that there is less pain." (A suggestion of a new possibility and expectation.) Listen for voice changes and look for anxious mannerisms.

- **Confidence**: "And, so you're ready now to fix it to heal quickly and well?"

We're good at making sure the 'just in case' equipment is ready; let's make sure that the patient is mentally ready in every way.

### # 243 Professional Growth and Development

**N.B.** Please check “Upcoming Conferences,” below, for new AAENP gatherings and in conjunction with ENA and ACEP. Direct links and brochures! Don’t pass it up!

Would you like staff nurses to be able to know or do ‘a little more’? Use the immediate teachable moment, of course, but consider checking with the Educator or CNS as to plans [verify, also, permitted scope, etc.], and contribute to a newsletter, or ideally co-opt the nurse with whom the issue arose to prepare an in-service with your assistance and backing, tag-teaming the presentation. *The best form of learning is preparing the subject matter for teaching.* Stepping out of the ‘providers’ charting room”, in this way, promotes unity with staff and breaks down walls. *Everything we do is collaborative.*

Better care. Better unity. Goals shared in a better way. Encouragement of staff development. Staff may decide to prepare for an extended role or qualify as ENPs, themselves!
# 244 Is Trouble BRUEing?

There is nothing more frightening to a caring parent than the sudden helpless fear that the infant suddenly died or is dying. If moments later, the child seems recovered: "What was that? Is it going to happen again? What should I do? Could he die?" Finding good answers puts us on the spot. Historically, increased awareness of 'Cot Deaths' led to the term Sudden Infant Death Syndrome. Babies who had strange spells colloquially were thought to be "Near-SIDS." To lessen confusion, the term became ALTE (Apparent Life-Threatening Event). For clearer definition and guidelines, the AAP replaced it with BRUE (Brief Resolved Unexplained Event) "intended to better reflect the transient nature and lack of clear cause and removes the 'life-threatening' label," Tieder, q.v.

The value of the new definition and the evidence for it is as a RISK STRATIFICATION TOOL to determine which child is Low-Risk who may, after history and physical, some observation and monitoring, be safely discharged. It is a diagnosis of exclusion; outliers will be at higher-risk requiring further focused evaluation. It is a springboard for discussion with parents of an otherwise healthy child as to risks/perils of extensive/expensive work-up which evidence suggests is unlikely to be fruitful. The parent is a sensitive monitor, of greater benefit, and should further help be needed—it is available. Sensitive and practical suggestions may be included (first aid and CPR training) in a general sense to give confidence and immediate rescue, which nonetheless does not suggest an imminent crisis.


# 245 Stomach Contents; Not In The Airway

Airway managers give great attention to preventing aspiration into the lungs. Success isn’t guaranteed. Unlike elective surgery, we cannot fast the patient, medicate him overnight, or do studies. Sonography, in other anesthetic settings, is in early studies to estimate the volume of gastric contents. Someday, this may help inform our approach to the unprepared patient.

Point-of-care sonography is rapidly evolving. These are initial studies, and not ready for clinical decisions in emergency care. Studies in our arena may yield future utility and minimize surprises.

Meanwhile, consider risk and practice caution. Decompression may have value. A smooth RSI may conquer. Positioning may help; be ready to instantly turn the patient to drain emesis. Know how to rapidly lower the table to Trendelenburg’s position so fluids puddle (for suctioning) below the glottis. Two suctions! Two Sources! (DuCanto Catheter™; HI-D® “Big Stick®”)


Robinson, M., & Davidson, A. (2014). Aspiration under anaesthesia: risk assessment and decision-making. Continuing Education in Anaesthesia Critical Care & Pain, 14(4), 171-175. (Free) [PDF]

# 246 Do I need to be worried?

There may be times when you are uncertain as to the intentions of ‘visitors’ to an injured ‘perpetrator’ or other combatant receiving care. Absent a skilled security service in your ED, this is a time for “I’m sorry, there are no visitors allowed right now” and getting hold of security, police, and administration before doing anything. These should be instantly available. Most active EDs need continuous on-site security service.

Security service, in this sense, means skilled professionals with training, powers, and authority similar to those of police. It does not mean overaged overweight chairwarmers who sometimes patrol with a clock-recorder, and who clearly never would qualify for ‘real’ law enforcement. When security services are needed, more is needed than just a flashlight, radio, and a “policy of ‘observe and report.’”

Many ED staff have pretty good judgment as to who might be a trouble-maker. Remember, of course, that appearances can be deceiving. We also are trained in ‘pre-violence indicators.’ Presence of pre-violence indicators should be reasonable grounds to exclude someone from a patient care area. Behaviors that might be furtive or shifty are less easy to define but should be reason to call for security presence.

In most North American jurisdictions, searches may only be done by properly constituted authorities, and then upon “probable cause.” Clues that might give rise towards an officer’s probable cause, among other requirements, include: visibility or familiar bulge of a weapon; the familiar sound of it clunking against furniture or the floor; an unnatural gait due to its weight or manner of concealment (boot or ankle; concealed in pants leg); ‘reassurance pats or checks’ to hold it in place or adjust position in waistband; fiddling with waistband or inside of garments. Pre-violence indicators may be darting or hovering the hand over the object.

Viewers of TV/Hollywood dramas have seen emulations of murders by ‘shank’ attacks in prisons with sharpened plastic toothbrushes hidden in scrubs, must realize that there are covert means and when there is murderous will, a way will be found, even in ultimate ‘Gun-Free Zones.’ Weapons may be hidden in hair, between fingers, in folded-back hoodies, or carried by a confederate.

Notwithstanding, there are many lawfully armed citizens, who may be carrying when needing emergency care. These people will not be your problem, being lawful in their lives, but may feel awkward or embarrassed under the circumstances. It may be necessary, e.g., sedated procedures, to offer them safekeeping of their sidearm until appropriately returned.

This information is provided for perspective by emergency care professionals and is not legal advice, nor does it authorize any action by any person not trained, qualified, and empowered to do so. Be sure of your local laws, policies, and restrictions.
# 247 A Fishy Reaction

EMS calls you while en route from a seafood restaurant with a patient who is described as distressed. His companion, a passenger in the ambulance, initially symptom-free, is now, ~30 minutes after the first patient’s onset, developing similar, but milder symptoms.

#1 has a florid flat red rash of the chest (no edema), including hot, peppery sensations of the skin, mouth, and throat. He is anxious, tachycardic, tachypneic and ‘short of breath’ with diminished, slightly wheezy breath sounds throughout. He denies any drug or food allergies.

#2 appears flushed, itchy, has palpitations, some abdominal discomfort, and mild headache. She, too, denies drug or food allergies. Both, and the remainder of their party, ate tuna in their meal. The others are well, but will bring samples of the tuna to the hospital for assay.

You decide to continue supportive treatment, with H1 and H2 antihistamines, nebulized bronchodilator combined with Ipratropium Hcl, observation and monitoring ± corticosteroid or epinephrine/adrenaline if there is grave worsening, but you anticipate an unremarkable recovery.

What happened in this case? Despite lack of allergic history, the symptoms seem histamine mediated; >1 victim further suggests this. Non-victims are probably due to not sampling the spoiled or contaminated portion. Naturally occurring Histadine in the muscles of dark-meat oily fish, typically from the Scombroid family (e.g., tuna, skipjack, or bonito; but not always, as cases have occurred with Mahi-Mahi or sardines) if not properly chilled or have bacterial contamination leads to conversion of Histadine to Histamine. Even if subsequently cooked, which may kill the bacteria, the Histamine that has evolved is not destroyed and causes adverse effects.

This is a notifiable public health illness. Histamine levels in the fish can confirm the source, and histamine or tryptase levels in the human can confirm the etiology. Standard antihistaminic treatment and support should suffice, although fatal cases are known. This episode will not create an allergy, and correctly stored and prepared fish in the future should be no problem. Histamine Fish Poisoning may be a better term, as non-scombroid fishes have been implicated also.


edema and coronary syndrome in a young healthy patient. *Cardiovascular Toxicology, 11*(3), 280-283. (Preview & Paywall) [PDF]


Schroeder, George, MD MS FACEP FAAUCM. *Pathophysiology, Diagnosis & Treatment of Scombroid Fish Poisoning*. *Journal of Free-Standing Emergency Medicine*. 10 August 2015.


# 248 The knife-point of necessity

We have all wondered how we would perform if crisis necessity compelled us to do a rescue Front-Of-Neck-Access. Especially if it was out of one’s Scope of Practice or authorized procedures. As I’ve heard it described, “If it was successful, one might be a hero; if not successful, one would then be the schmuck who used to work here!”

Nonetheless, the possibility of encountering a critical airway emergency always exists, and with a likelihood that higher personnel or resources are not there. It is best to have documented official training of appropriate standard. In any emergency, to paraphrase Louis Pasteur, “success favors the prepared mind.” Emergency Professionals live their convictions and prepare their minds diligently for all circumstances, even the uncommon.

Read, below, the experience of a New Zealand Midwife who acted when needed and saved a life. Additional useful links to prepare your mind are also listed.


*Surgical Airway (Cricothyrotomy) Performed by Ram Parekh* from Scott from EMCrit.

©Advanced Emergency Nursing Journal 201_ 8
# 249 Personal Survival Kit for *those* shifts!

Many emergency professionals make a habit of ‘Every Day Carry’ of practical items for unexpected needs. In EDs (and other emergency missions), the most important person to save is *our self*, to bear up longer under adverse conditions, see that next patient *now*, and to recover as quickly and completely if brief respite comes.

I imagine that you already bring your ‘Peripheral Brain’ of reference data on cards or smart phone. At least one spare pen that you like. Spare batteries or charging cord? Music/Video player. Grooming aids and cosmetics. PRN meds for one’s allergies or pain.

Small kits in an ‘Altoids®-type tin or a pouch are popular. Consider:

- Menthol Inhaler to mask unpleasant odors.
- Small toothbrush & paste, breath freshener.
- Lip Balm.
- Hand Sanitizer & Lotion.
- Body wipes.
- Safety pins for clothing repair.
- Gum, candy, or protein bars.
- Spare Contact Lenses, *etc.*, or spare glasses.
- Preloaded card for fancy coffee, food.
- Caffeine tablets (when you really can’t slow down).
- Earplugs & sleep mask, if there’s a safe place to nap.
- 24-hour supply of regularly taken medicines.
- Preloaded card for sudden money needs (not tied to your accounts).
- $50-$100 emergency cash (taxi home, car tow, plastic ‘declined’).
- Reminder how to find/lock/delete your cellphone data, if stolen.

If you have the luxury of a locker: spare shoes, clothing change, outer garment for unexpected weather. Remember a ‘disaster’ (not a drill) is *when you come to work and don’t leave until three days later --still in the same clothes*.

# 250 Do you really need that line?

A best clinical poster at Australian College of Emergency Medicine presents an intervention to reduce those “*just in case*” IV starts that don’t actually get used. Practice,
before and after, was studied; fewer IVs were started, those that were started were more likely to be used in the ED or upstairs, savings in costs and staff time were found.

This is a promising field for study and change. There are cultural practices to question. We tend to assume that patients are sicker than they look. Busy EDs develop workarounds to hasten flow that drive costs and complexity upwards. Protocol-driven EMS crews and nurses may tend to over-treat, and to ‘CYA’ with the IV that may not be absolutely needed, or to send tests that may be reasonable but discretionary. It’s possible to increase the patient’s bill, through good intentions, by large amounts.

Front-end triage by providers is said to focus initial care efforts with time and cost savings compared with conventional triage and nurse actions before exam by a provider.

So, let’s look at what we do, and why we do it, and see if some efficiencies and economies can be effected. It may be worthwhile.

The review of the study, from an evidence-based and skeptical viewpoint, is from “The Skeptic’s Guide to Emergency Medicine.”


# 251 Gastric Rupture & Tension Pneumoperitoneum

Though you may rarely, or never, see this complication (I truly hope so), it can progress from inklings of “what, the hell?” to massive astonishment!

One cause of Tension Pneumoperitoneum is Gastric Rupture which can occur from esophageal intubation, usually (but not always) along the lesser curvature of the stomach. Other iatrogenic causes are bag-valve-mask ventilation, difficult intubation, perforations due to instrumentation especially with insufflation during endoscopy, during surgery; by blunt trauma, or spontaneously through diseased or damaged tissues, including perforation of a hollow viscus, or carcinomatosis. Pneumomediastinum can leak to the abdomen.

If not detected quickly, the hugely distended abdomen can push the diaphragm up impeding ventilation and alter cardiac output by mediastinal shift. The high tension becomes an abdominal compartment syndrome, and may threaten distal circulation to the lower extremities.

If a non-endotracheal advanced airway has been placed in the field, and function is satisfactory, do not hasten to intubate ‘around it’ as this an awkward circumstance that can lead to esophageal intubation past the other device. Consider waiting until ‘Return Of Spontaneous Circulation’ is stable, when the procedure can be done in calmer fashion, possibly augmented by video or flexible laryngoscopy.
This is a clinical diagnosis. The patient may be too unstable for a scan. Cross-table portable X-ray may be all that can be done initially. Emergency Needle Decompression or a pigtail catheter may temporize. Do other imaging when feasible. Surgical repair is needed.


Sharma, Rohit, Dr. & Jones, Jeremy, Dr., et al. Pneumoperitoneum. Radiopaedia.org. (Blog). No Date. Accessed 04/02/2018. “Revision I created almost 9 years ago by Dr Jeremy Jones.” “Current revision created 5 days ago by Dr Rohit Sharma."

# 252 'Tactical Tampons'

For some two or more decades, there have been unverifiable assertions that ordinary vaginal tampons have utility as ‘wound plugs’ for gunshot wounds, for epistaxis, that
frequent use has been for such by military medics, and thus is a bona fide
recommendation for those who prepare for such emergencies. I have always considered
such comments as 'not proven', unlikely, unverifiable without documentary evidence or
testimony, and likely not an official policy.

A Canadian web blog on tactical medicine includes it in its list of "Myths of Tactical
Medicine" (its most popular download). Many tactical medicine writers support an
evidence based medicine approach, using military "lessons learned", and keeping care
relevant in reality – rather than uncritical acceptance of past dogma.

Modern terror attacks increase the likelihood of life-threatening bleeding, and strong
efforts are being made to update the civilian approach to stopping bleeding. Tampons
are not effective, and, despite the attractive novelty imputed, should not be used. They
are not perfect in their original purpose.

Major bleeding must be dealt with first, fast, and effectively. Pressure must be applied to
the source of bleeding. Shutting off flow proximally may be needed. The bleeding point
should be accessed, and wound packing with pressure, until definitive control and repair
is done. Unlike a tampon, the dressing in shape should resemble a champagne cork with
its base at the bleeding point, complete filling of the wound, and a 'mushroom cap' on
top to allow circumferential bandage pressure. Hemostatic agents may be used, but
gauze works as well if correctly used.

Official responders need to be well-trained and equipped. Hospital workers need
likewise, to be prepared for a disaster that comes to them or occurs within.
Exsanguinination is rapid. Without blood, life will not be supported. Death by every drop.

Mikkelson, Barbara. Mikkelson, David. Tampons to the Rescue. Tampon used to

Stewart, Creek. The Swiss Army Tampon: A Life-Saving Wilderness Survival

Whiskey Delta Gulf. Myths of Tactical Medicine. Whiskey Delta Gulf Blog. © Copyright
Whiskey Delta Gulf 2012.

Dennis Filips, MD. 10 Hemorrhage Control Myths. JEMS Journal of Emergency

Harris, Bill. 5 myths about Tourniquets. TraumaMonkeys.com. 2014.

Peter P. Taillac, MD, FACEP , Scotty Bolletter, BS, EMT-P [P], A.J. Heightman, MPA,
EMT P. Wound Packing Essentials for EMTs and Paramedics. JEMS – Journal of

Peter Taillac, MD. What Do I Do with this Hemostatic Gauze?. [pdf of

# 253 Penetrating Trauma … That Sucks!
A gunshot victim suddenly arrives “WBEMS” (Without Benefit of EMS (Emergency Medical Services), at your ‘quiet’ Emergency Department. Looks awful. Pale. Gasping. Funny asymmetric chest movement. Not much blood. As you lift the shirt, a pencil-sized wound is revealed. What to do? Immediately, you apply (gloved) hand pressure to the wound. You’re “not a trauma center” so chest tubes and seals are in another room.

What now? Your hand must stay there until the wound is sealed. Scan the room. “Of course!” “Give me the Defibrillator Pads!” Eh, voila! Nice sticky defibrillator pads to cover the wound, and a companion wound, say, an exit, if there is one.

As your institution is “not a trauma center”, you usually ‘expect’ cardiac, so the pads are there. If the chest is bloody, grab one of the intubation towels and wipe the chest to improve adhesion.

ATLS no longer specifies a “three-sided occlusive dressing” for which evidence is lacking. However, whichever dressing you use, it is vital to monitor the chest for progressive pneumothorax which might achieve a ‘tension’. Survival is a balance between air (or ventilator breaths) coming in vs the rate of escape, if any. Tissue may interpose a barrier to escape of what otherwise would be an ‘open’ pneumothorax, or ‘minute volume’ of ventilations may exceed ‘minute volume’ of escape. In the ventilated patient, pneumothorax is more likely to achieve tension and to shift the mediastinum impairing cardiac output, whereas the spontaneously breathing patient is less likely to have a ‘shift’.


Littlejohn, L. F. (2017). Treatment of Thoracic Trauma: Lessons From the Battlefield Adapted to All Austere Environments. Wilderness & environmental medicine, 28(2), S69-S73. [PDF]

©Advanced Emergency Nursing Journal 201_


**# 254 Odd rashes, itching, scratching**

Don’t forget a very useful ED tool is the (typically) illuminating magnifying glass with a Wood’s (long-wave ultraviolet A) Lamp. There’s usually one, sometimes in a supply room, or in a pediatric room.

Frequently used to check for ringworm (tinea capitis), with the UV lamp, or for sexual assault exams (wounds & fluorescence of semen; however, more specific light frequencies and filters are now recommended), it’s useful to detect Ethylene Glycol (“anti-freeze intoxication) in urine by its fluorescence.

The unexplained ‘fingernail cellulitis’ from scratching the itch may be explained by finding the bites that caused it. Using magnification with good light, or UV when indicate, makes inspection easier and more detailed.

Patients with “invisible” bites and lesions (“Don’t you see them? They’re going in and out of my skin.”) can be assured of your carefulness by a conspicuous exam with the lighted magnifier and Wood’s Lamp. (“No, I can’t see them, even with this special light, but I do believe that what you’re feeling is bothering you. I’d like you to follow up with someone who can help more.”)

Dogs, cats, and birds have long been pets. More exotic pets (reptiles, rodents) are joined now by increasing numbers ‘backyard chickens” and other animals who share their owners’ lives as pets, more than livestock. Infestations of mites and other ‘critters’, now enter the differential of bites, skin irritations, or worse, lung infections from avian dander, and allergens that exacerbate asthma, and other less urban substances. Remember to ask about ‘other’ animals, as a generic ‘pets’ question may only elicit the household animals.
Worms in some animals, can be acquired by humans also, and should be sought where indicated. Modern suburban practice is truly a blend of urban and semi-rural concerns.


**# 255 Shoulder Reduction**

Dislocated shoulders are painful. Reduction of it is painful, too; Prompt reduction is beneficial.

A quick, but careful, neurovascular exam, followed by point of care ultrasound may eliminate some of the slow-downs if X-ray is swamped.

Technics are numerous; some require sedation and recovery; some can be done with intraarticular anesthesia; some with talking (or hypnosis) and manipulation only. Learn several methods and become adept at those which work best for you and are simplest, if possible.

The more ‘fresh’ the injury, generally, the reduction is easier due to less spasm.

It’s useful to keep talking with the patient to distract his attention away from the injury.

Your best cheerful, confident, and engaging ‘bedside manner’ will lesson anxiety, tension, and therefore, pain. If you are able to achieve sedation-free reduction, the burden on the department is less and discharge can be done without ‘recovery’.


Mellick, Larry, MD. **Ten Ways To Reduce A Dislocated Shoulder**. YouTube Video. Published on Aug 13, 2015.


# 256 Does ‘Altered Mental Status’ alter our own?

Dr. Natalie May (UK) presents an interesting review of two American papers questioning ‘presumed’ alcohol intoxication and the physical clustering of those patients raising diagnostic challenges of overcoming biases, anchoring, and triggers for further workup.

Of “29,322 patients with presumed alcohol intoxication – 1,875 had negative breath alcohol and were included in their analysis. That’s 6.39% of patients presumed to be intoxicated with alcohol who weren’t {Note: My emphasis} – around 1 in 16 patients”. 10% were admitted, with 1% to the ICU. This was a large center that uses breath alcohol screening. Dr. May notes that this is uncommon testing in the UK.

Do you have a standard screen or track for poor trajectory of clinical progress? How suspicious are you in seeking other problems, when alcohol is ‘presumed’ to be the main problem? Blood alcohol testing that I’ve seen was to exclude the diagnosis, confirm toxic (very-high) levels, check proportionality to the level of consciousness seen, or to check for other alcohols if that was an important possibility. Check glucose always. Choose other tests based on possible confounding, or masked, diagnoses.

Are there targets for open-minded re-exam? Failure to progress, or “reattendance” argue for more aggressive diagnosis.

An example used in first aid classes was that of a man found unconscious on the ground near his ladder. His breath is boozy. What happened?

- Drunken fall from the ladder?
- Fall from standing height?
- Drank his lunch and fell asleep?
- Felt unwell and took a drink?
- Never got on the ladder; had a stroke?

Be careful with assumptions. Quiz EMS about scene observations. Thorough exam and testing. Review/Reexamine hourly or with any change.


# 257 Caring for VIPs; VIP Syndrome; Ethics
As with other patients, caring for VIPs can be satisfying or frustrating. Further, there is some hazard that care given may, by distraction or influence, vary from best and prudent care.

- Registration may be by pseudonym, address may be corporate rather than personal.
- Prompt privacy needed to avoid attracting stares and overhearing.
- The entourage may be helpful, or not; their loyalty is to the boss.
- Many celebrities can be ‘ordinary folks’, some will have special requests, or want to leave for the air flight.
- As the Joan Rivers case showed, VIPs may suffer from the wrong care and attention due to deference, ‘ga-ga’ silliness from professionals, and specious reasoning in care or crisis. VIP Syndrome occurs when the patient is harmed by the consideration of status.
- Stick to standard care and unaltered procedures, focusing on the patient and disease. Maintain good communication and teamwork. Beware of concessions and compromise.
- Administrators, Chairpersons, Consultants, may want to pay courtesy calls or take part in the care, or request privileges for the VIP.
- VIP or preferential treatment arouses some ethical questions as to motivation and whether it interferes with the needs of others.


Alfandre, D., Clever, S., Farber, N. J., Hughes, M. T., Redstone, P., & Lehmann, L. S. (2016). Caring for ‘very important patients’—ethical dilemmas and suggestions for practical management. The American journal of medicine, 129(2), 143-147. (Abstract & Paywall) [PDF] [PDF; free source]


# 258 Is that pelvis broken?

A nice tip originates from a large Australian centre (The Alfred Hospital, Melbourne, Victoria) in a small study.

Patients were prospectively screened with a test of straight leg raise eliciting pain and then X-rayed to determine if the pelvis was fractured. From the cohort of 328 patients, 35 patients had proven fracture. 32 alert patients (GCS=15) could not straight leg raise or did so only with pain. "Sensitivity of 91.43% (95% CI: 76.94–98.2%) and a negative predictive value of 98.57% (95% CI: 95.88–99.70%)" was claimed. The other 3 patients with fracture could lift without pain; these patients had GCS<15. For the sub-group who were alert, there was 100% sensitivity and 100% specificity in the test.

Older methods of examination by 'spreading' and 'squeezing' the Iliac Crests and pressing upon the Symphysis Pubis have been criticized as increasing injury that may dangerously lead to increased concealed internal hemorrhage which can be fatal.

As always, be cautious in eliciting subjective symptoms in patients who are impaired.

This report is gaining traction among various emergency professionals with presently 127 retweets.
