RESURRECTION EMERGENCY MEDICINE

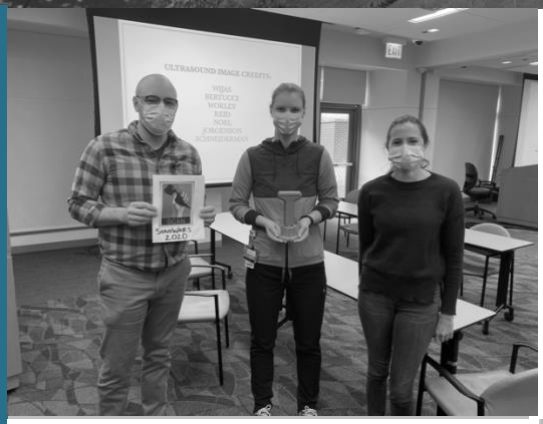
FOAM & Education Newsletter

December 2020
Volume #4

Welcome to Rez's #FOAM Newsletter

9+ months into the pandemic, multiple waves later and we finally have an end in sight with the COVID vaccine! Hopefully everyone's staying safe & has been able to get vaccinated. This month's newsletter will include some COVID updates including an approach to discussing code status & a review of finger thoracostomy. We also did the usual POCUS update & literature review.

Your 20-21 Education Committee
Walid Malki
Jon Reid
Lola Reingold
TJ Stolz
Yalan Vu



POCUS Update: Ocular US for Posterior Chamber Pathology & ICP

Palliative Consult: How To Manage Code Status Discussion in ED

December FOAM Highlights

Podcast of The Month:
EM Cases: Liver Emergencies

Blog Post of The Month:
EmDocs: COVID-19 In The Elderly

Procedure of The Month:
Taming The SRU: Finger Thoracostomy

Palliative Consult: How to manage code status for seriously ill older adults in respiratory failure (Link) by Walid Malki

Bottom Line: Treat the code status discussion as any procedure – have a stepwise approach – it is as critical as the intubation that may or may not follow.

Step 1: Establish urgency & elicit understanding
Step 2: Break the bad news (ask for permission before you do – gives them sense of control & time to prepare)
Step 3: Develop therapeutic alignment (use "we", key step to building trust)
Step 4: Ascertain baseline function
Step 5: Explore the patient's values/goals and then summarize goals
Step 6: Summarize entire discussion
Step 7: Make recommendation (whether it is full, limited or comfort care)

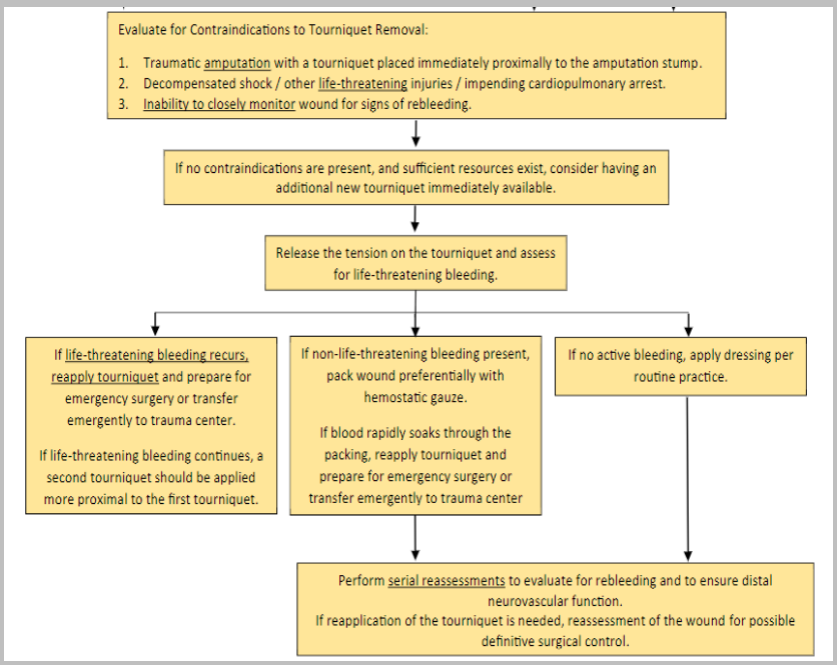
Check page 3 for more figures including statistics re: prognosis after ED intubations

Source: "Managing Code Status Conversations for Seriously Ill Older Adults in Respiratory Failure" by Ouchi et al, Annals of EM, Dec 2020

Removal of pre-hospital tourniquet in the ED by Lola Reingold

- Start with a trauma surgery consult before take-down to minimize tourniquet time and/or time-to-OR
- Tourniquets get worn out with use: loosely place a new tourniquet adjacent to old before taking down the old one in case life-threatening bleed recurs
- Non-life threatening rebleeds should be packed with hemostatic gauze & held with pressure → pressure dressing
- Frequent, serial re-evaluation to assess for need for further intervention

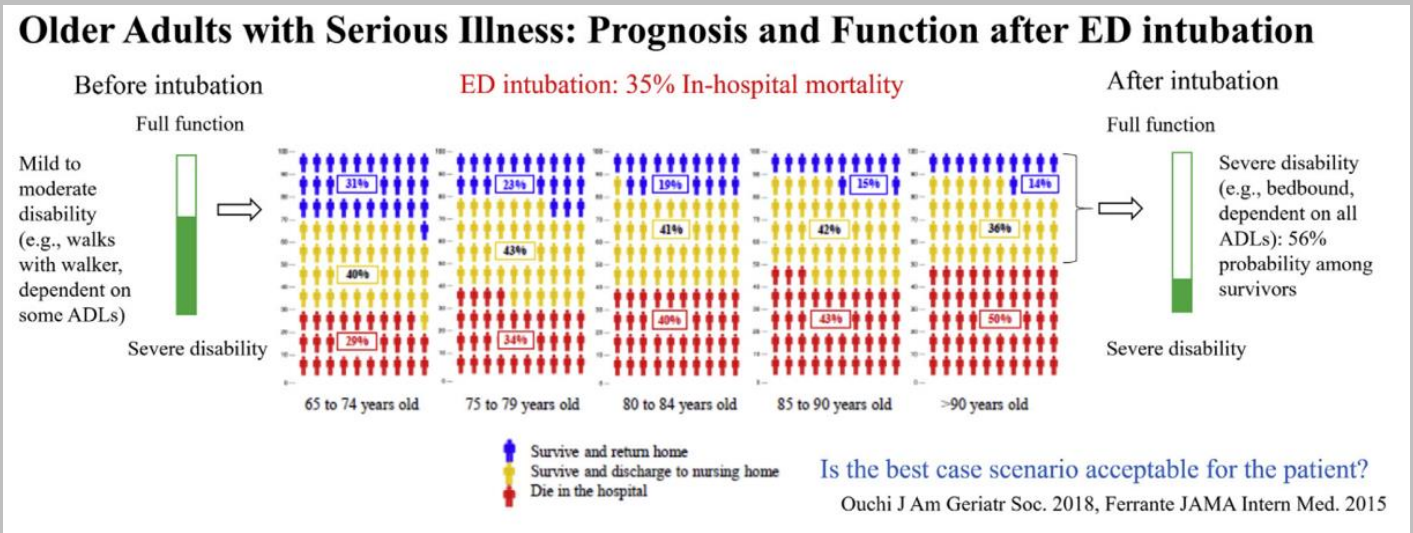
Source: "Removal of the Prehospital Tourniquet in the Emergency Department" by Levy et al, Journal of Emergency Medicine, Dec 2020



Ocular POCUS for Posterior Chamber Pathology & Elevated ICP by Yalan Vu

- For a summary video, check out Core Ultrasound (Link)
- **Elevated ICP**: Optic Nerve Sheath diameter sensitivity 0.90%, specificity 0.85% (1)
  Look for: diameter >5mm. Measured 3mm from inner posterior wall of eye from outer wall to outer wall of optic nerve
- **Retinal detachment**: sensitivity of 96.9% and specificity of 88.1% (2)
  Look for: hyperechoic wavy line in posterior chamber that interfaces with the optic nerve
- **Vitreous detachment**: 42.5% sensitivity and 96.0% specificity (2)
  Look for: hyperechoic wavy line that does NOT interface with optic nerve
- **Vitreous hemorrhage**: 81.9% sensitivity and 82.3% specificity (2)
  Look for: hypoechoic/hyperechoic mush in posterior chamber that swirls with eye movement

Sources:
1. Dubourg J, Javouhey E, Geeraerts T, Messerer M, Kassai B. Ultrasonography of optic nerve sheath diameter for detection of raised intracranial pressure: A systematic review and meta-analysis. Intensive Care Med. 2011;37:1059–68.
2. Lahham S, Shniter I, Thompson M, et al. . Point-of-care ultrasonography in the diagnosis of retinal detachment, vitreous hemorrhage, and vitreous detachment in the emergency department. JAMA Netw Open. 2019;2(4):e192162. doi:10.1001/jamanetworkopen.2019.2162



Know the statistics when discussing code status and goals of care - 1 in 3 older adults (50% of adults >90 years) will in the hospital after intubation. Among survivors, greater than 80% will be discharged to places other than home

Goal: Make patient-centered recommendations regarding intubation for patients who may be at high-risk for poor outcomes. After establishing that advance directive does not exist, complete the following steps:	
Steps	**What to say**
Elicit Understanding	I wish we met under different circumstances. Your [father] is very sick and have to decide quickly about [his] care. What have you heard about what happened today?
Break bad news	**Ask Permission:** I am afraid I have serious news. Would it be OK if I share? **Disclose**: Your [father] is having a very difficult time breathing due to a [severe pneumonia]. With his serious health issues, I am worried that things may not go well, and it's possible [he] could even die.
Align	We need to **work together quickly** to make the best decisions for [his] care.
Baseline function	To decide which treatments might help [his] the most, I need to know more about [his]: What **type of activities** was [he] doing day to day before this illness?
Values *Use question(s) as appropriate*	Has [he] **expressed wishes** about the type of medical care [he] would or wouldn't want? How might [he] **feel if treatments today led to**: Inability to return to [his] favorite activities? Inability to care for [himself] as much as [he] does? What **abilities are so crucial** that [he] wouldn't consider life worth living if [he] lost them? **How much** would [he] be willing to go through for the possibility of more time? Are there states [he] would consider **worse than dying**?
Summarize	What I heard is that your [father] considered ___ most important, and that [he] would consider treatments that result in ___ unacceptable. **Did I get that right?**
Recommendation	Based on what you've shared with me, **we would recommend:** • Intensive treatment focused on comfort; or • Intensive treatment focus on recovering from illness We will use all available medical treatments that we think will help [his] recover from this illness. For [his], this means: • Supporting [his] body in recovering from this illness without treatments that could make [his] more uncomfortable, while do everything we can to assure that [he] is comfortable and peaceful; or • Supporting [his] body in recovering from this illness with intensive treatments, including ventilators, while also doing everything we can to assure that [he] is as comfortable as possible. I worry that even with maximum care, [his] body may still tire out. The admitting teams will support you over the coming days with upcoming decisions. Does this sound ok?
Document the conversation	

Stepwise approach to discussing code status in elderly with respiratory distress needing intubation