MACEP News

Elijah Berg, MD, Editor ▫ November 2002 ▫ Volume 27 ▫ Number 3

President's Message

Kimberly Melloni, MD, FACEP

Over the years, MACEP has become a powerful force in the realm of Emergency Medicine here in Massachusetts. There have been hours of tireless work done by our leaders on behalf of the "pit docs" in this state. As we continue to strive toward greater goals for our specialty and our organization, we realize that we can only do that by tapping into the great resources we have in our membership. When I entered my Presidency in the spring, one of my goals was to implement the strategic plan developed during MACEP's spring retreat and to restructure the MACEP governance in an effort to involve more of the membership in our activities. With the support of the Board of Directors and Executive Committee, we have finalized a governance plan that I hope will attract many more of our members to participate in the state's emergency medicine issues.

Knowing that time is precious especially to those of us who give up weekends and holidays on a routine basis in the name of patient care, we began to plan our governance structure with the goal of maximizing physician involvement allowing for a large range of time commitment options.

In MACEP's prior governance, the Executive Committee, Board of Directors and most of the committees were composed of many of the same people. Although those involved have been tremendously talented, committed and reliable, I think it is important to have as much input as possible for the decision making body of MACEP.

> "We have finalized a governance plan that I hope will attract many more of our members to participate in the state's emergency medicine issues.

In the new structure, the executive committee will continue to be comprised of the President, President Elect, Past President, Secretary, Treasurer and a Member at Large. The Board of Directors will be made up of 15 physicians, from which the Executive Committee will be nominated. Unlike our prior structure, the physicians on the Board of Directors will no longer be chairs of committees, but will rather serve as liaisons to the committee chairs, thus providing guidance and years of experience without actually heading the committees. Our committee chairs will be from the membership at large and will be responsible for populating their committees with clinicians from around the state. This transition of chairs will be accomplished over the next two years. Members of the committees can have a variable time commitment, ranging from active year round participation to occasional project involvement. With such flexibility built into the system, I anticipate much higher participation willingness by the general membership. Since the chairs are charged with appointing their own committees, they are more likely to involve colleagues and friends who may have not been involved before. I have also asked that every committee chair involve at least one emergency medicine resident on their committee as we often get very different and invaluable views from our residents on the issues at hand.

So with this in mind, please get involved! MACEP is a wonderful organization fueled only by the insight, ingenuity and commitment of emergency medicine physicians. With the guidance of such a dynamic, driven group of individuals, we can do nothing other than succeed!

See PRESIDENT, next page

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PRESIDENT continued

For those of you who may be interested in participating in a MACEP committee, please contact Susan Beer, Executive Director (sbeer@macep.org). Thanks again for all of your support!

Current Committees and Chairs:

Membership Services/Products Committee:
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Brien Barnewolt, MD, FACEP
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Daniel Corboy, MD
Reimbursement/Managed Care Committee: Elijah Berg, MD, FACEP
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MACEP Risk Management Qualifies for HUM Discount

In recognition of the value of MACEP's Risk Management program developed through the oversight of past president Dr. Michael Doyle, HUM/PIAM has agreed to offer their clients a 5% discount for two years on their base malpractice premium.

In order to qualify, the physician must pass the six module exam with a score of 90% or better. The test is available on MACEP's web site at www.macep.org.

For further details, call your broker or PIAM at (781) 434-7525 or (800) 522-7426.

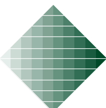
MACEP Welcomes New Members

Philip Anderson, MD
W.Gregory Baxter,MD
James Gordon, MD
George Kondylis, MD
Stephen McElroy, MD
Mary Patricia McKay, MD
Andrew Old, MD
Sucharitia Paul, MD
Peter M. Pillitteri, MD
Denise Rollinson, MD

Summary of ACEP Council Resolutions

The 2002 Council considered 36 Resolutions: 20 were adopted, 9 were defeated, 1 withdrawn, 2 were referred to the Board of Directors, 4 referred to the Council Steering Committee. There were 11 Bylaws amendments submitted to the Council. The council adopted 2 that required a 2/3 affirmative vote of the Board of Directors. The non-bylaws resolutions adopted require a simple majority vote and a 3/4 vote of the Board to amend or overrule. The Council adopted 6 amendments to the Council Standing Rules. These do not require adoption by the Board.

The Council also reviewed reports from the Crowding Resources Task Force and Terrorism Response Task Force. The reports will be filed as submitted and made available upon request. The dispositions of policies as stated in the Sunsetting Policy Report was also accepted.



MACEP News

MACEP News is published six times a year. The deadline for receipt of all materials is the first of the month of publication.

Display ads:	1 Issue	6 Issues
Full-page	$150	$750
Half-page	$100	$500
Quarter-page	$ 60	$300
Classified	$ 50 (per issue, 75 words)	

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Information That Belongs in Your ED

As an emergency physician, you know first hand that good information provided at the right time, in the right place, from the right source can make a difference. MACEP can help you provide that information.

Aftercare Instructions

Improve and standardize aftercare in your emergency department with these up-dated, comprehensive, and easy-to-read instructions for the patient aftercare of more than 50 common medical emergencies from A (abdominal) to W (wounds). The **MACEP Aftercare CD** contains instructions sheets that can be individually printed out, edited as needed, and given to your patients to take with them when they leave your care. The cost to order is $250. Mail or fax your order using the form to the right.

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Academic Affairs ~ Ron Walls, MD, FACEP; *Member*

Educational Meetings ~ Carlo Rosen, MD, FACEP; *Member*

Federal Governmental Affairs ~ Bruce Auerbach, MD, FACEP; *Chair*

Emergency Medicine Practice ~ Alan Hirshberg, MD, FACEP; *Member* and Charlotte Yeh, MD, FACEP; *Member*

Research ~ Carlos Camargo, MD, Dr. PH; *Member*

Scientific Review ~ Carlos Camargo, MD, Dr. PH; *Member*

Coding/Nomenclature Advisory ~ Elijah Berg, MD, FACEP; *Member* and Rajat Chand, MD; *Member*

Public Relations ~ Stephen Epstein, MD, FACEP; *Member*

State Legislative/Regulatory ~ Mark McGuire, MD; *Interest*

Section Affairs ~ Miriam Aschkenasy, MD; *Interest*

Academic Faculty Position Available

Full time/part-time EM academic faculty position at Tufts-New England Medical, the principal teaching hospital for Tufts University School of Medicine in Boston. Must be BC/BP in EM and must be committed to academic growth and excellence. Outstanding research and teaching opportunities and support, including protected time. Excellent working conditions, salary and benefits. Responsibilities include supervision of EM, Med, Surg, Pediatric and OB-Gyn residents and TUSM students rotating in the ED. T-NEMC is a Level 1 Pediatric Trauma Center, sees 42,000 visits/year in a state of the art facility, is one of twelve Agency for Healthcare Research and Quality (AHRQ) Evidence-based Practice Centers and is one of only two designated United States Cochrane Centers, designated as the New England Cochrane Center. Academic appointments in Department of Emergency Medicine at TUSM. Contact Brien Barnewolt, MD, Chairman, T-NEMC, Dept. of Emergency Medicine #311, 750 Washington St., Boston, MA 02111. (617) 636-4720, bbarnewolt@lifespan.org.

Case Management: Headache, Malaise and a Rash

By Elijah Berg, MD, FACEP

CC: Headache.

HPI: It is July. A 32-year-old man arrives with a complaint of a diffuse headache. His headache started about one month prior to presentation, and has been waxing and waning but has mostly been constant. It seems to get much better after he uses Motrin. He also states that he was feeling feverish during the first week or so when his symptoms started. On review of systems he states that he noticed a red, palm sized circular rash on his right lower chest at around the time his headache started, which went away after a few days. The rash was not itchy. He has also been feeling generalized malaise and joint pains for the past month. He lives in Massachusetts in a somewhat rural town. There has been no abdominal pain, no focal weakness and no cough. He does not recall any tick bites.

ROS: Per HPI otherwise negative.

PMHX: He is generally healthy without prior headaches for which he has sought medical attention.

MEDICATIONS: None.

SOCIAL HX: He is married; he works as a landscaper. He is a non-smoker.

Physical Exam

GENERAL: He appears in mild distress from his headache, he is speaking in full sentences and is calm. He is well developed and well nourished.

VITALS: BP 148/78; RR 16; PULSE 110; TEMP 98.9; Pulse Oximetry 99%.

HEAD/NECK: No tenderness or signs of trauma. Flat neck veins. No bruits.

CHEST: No tenderness. No retractions.

HEART: Regular rhythm, there are no murmurs.

LUNGS: No wheezes or rales. Lung sounds are symmetric.

ABD: Soft, not tender, no masses or bruits.

EXTREMITIES: No edema or cyanosis. No joint swelling noted.

NEUROLOGICAL: Motor, sensory and cerebellar exams are normal. Fundi are unremarkable.

SKIN: Careful exam reveals no rash.

Questions

1) What infectious diagnosis should be considered?

Lyme disease. This person has symptoms consistent with lyme disease. Lyme disease symptoms are often consistent with other benign viral infections, however this patient lives in an endemic area, presents during the time of year when lyme is transmitted, and remembers a circular rash that accompanied the onset of symptoms. Additionally, he works outdoors, which raises his risk.

2) Why is the season so important when considering the diagnosis of lyme disease?

Lyme disease is a tick-borne illness that results from an infection of the spirochete *Borrelia burgdorferi*. The Ixodes tick (deer tick) carries the spirochete; the lymphal and adult stage activity of this tick peaks in the summer months. The ticks (in the larval and nymph stages) like to attach and draw blood from the white-footed mouse, which is the most important reservoir of *Borrelia burgdorferi.* Once the tick has had a blood meals in the larval and nymph stages (possibly from an infected mouse), it can proceed on to the adult stage of it's lifecycle; as an adult the tick prefers to feed on white tailed deer (the deer itself is not a host for *Borrelia burgdorferi*). The nymph and adult and ticks also attach themselves to a humans and it is they who transmit disease (mostly the nymph).

3) What does an Ixodes tick look like and how long does it need to stay on to transmit Borrelia Burgdorferi?

Sometimes the patient comes in with the tick itself and will ask the emergency physician if it can cause lyme disease. As a reference, the Ixodes tick is about 50% of the size of the ticks that usually attach themselves to a dog, and they have a red/brown appearance. Go to *www.tickinfo.com* for pictures of the Ixodes tick in various stages of development and engorgement, and to see it compared to other ticks.

A tick must be attached to a human for at least 24 hours in order to transmit the spirochete, and possibly up to 72 hours. The spirochete lives in the gut of the tick, and when the tick begins to have a blood meal the *Borellia burgdorferi* spirochete slowly moves towards the salivary glands of the tick; this is the process that requires 24-72 hours. If the tick has been attached less than 24 hours it is believed that there is a negligible chance of transmission of the spirochete.

3) What does the rash of lyme disease look like, and how often is it present?

The rash of lyme disease is erythema migrans. It usually presents approximately one week after the tick bite, but can start as early as one day and up to about 5 weeks after the bite. Erythema migrans is believed to be present (but not always noticed) in about 80-90% of patients with lyme disease. It can present as a central red patch with varying shades of redness within it, and can be of varying shapes, or can present as the more classic "bullseye" lesion with a central red area surrounded by a clear area, and another outer red ring. However, the rash is not always the classic one; in one study the classic bullseye lesion only appeared in 37% of the cases of confirmed erythema migrans. Most lesions are flat but can be vesicular, crusted or necrotic. The rash occurs in stage 1 of the disease (days to weeks after the bite) and is almost always accompanied by constitutional symptoms such as malaise, headache, arthralgias and fever.

4) What are the three stages of lyme disease?

There are three of the stages of lyme disease:

Stage 1 (early localized lyme disease): Occurs in the first days to weeks, and manifests with erythema migrans with or without constitutional symptoms. Fatigue, malaise, arthralgias and myalgias are common complaints.

Stage 2 (early disseminated infection): Occurs in days to months after the initial infection. The heart and nervous system and are the primary organs involved. 20%-50% of patients develop a recurrent rash of erythema migrans in this stage. Headaches, cranial neuropathies, encephalitis and meningitis can occur. Cardiac symptoms develop in up to 10% of patients with lyme disease. Lyme myocarditis frequently presents with palpitations, dizziness, shortness of breath and syncope; AV blocks are the most common finding with about 50% having high degree blocks.

Stage 3 (late disseminated infection): Occurs in months to years after the initial infection. Manifests with arthritis occurring in intermittent exacerbations over years (most commonly the knees), and a variety of neurological symptoms involving the central and peripheral systems; subtle cognitive difficulties and fatigue can be found in this stage.

5) Who should be suspected of having lyme disease?

Lyme disease can easily be confused with many other processes and is easy to escape diagnosis. As we practice in Massachusetts our index of suspicion should be higher than for ED physicians in other areas of the country. Any clinical feature may appear alone, come in intervals and may appear at any stage of the disease. Some patients who have late symptoms may not have experienced early symptoms. The initial skin lesion of erythema migrans, if it is the classic bullseye, is pathognomonic for lyme disease. As many of the symptoms have similarities common viral infections, the diagnosis can be challenging. One differentiating symptom from other viral illnesses is that lyme disease does not cause diarrhea. A specific feature of lyme disease is migratory musculoskeletal pain. In the end it is can be a difficult diagnosis to make; because we practice in an endemic area lyme disease must be considered in anyone with a rash and symptoms consistent with a viral illness (this is especially true in the months of May-September).

6) How is lyme disease diagnosed?

As early treatment with antibiotics is beneficial, usually treatment begins based on history, clinical findings and exposure to an endemic area. Identification of *Borrelia burgdorferi* from cultures of body fluids including blood, arthrocentesis and lumbar puncture is very unusual. Serologic

LYME DISEASE continued on page 6

LYME DISEASE continued from page 5
testing is the most reliable means of confirming infection; testing consists of an initial ELISA assay, which if positive is followed by a Western blot. A positive Western blot confirms antibodies to *Borellia burgdorferi*. However, it can take several weeks for a patient to develop an immune response after exposure, and if the serum is tested early it may yield a negative result. There is a urine antigen test that has been reported to be unreliable.

6) How is lyme disease treated?

Treatment depends on what systems are involved. Early disease (local or disseminated) is treated with oral antibiotics, usually doxycycline or amoxicillin, for 14-21 days. If there is an isolated facial nerve palsy treatment would still be for 14-21 days with oral antibiotics. If there is encephalitis or meningitis treatment is for 14-28 days with daily IV ceftriaxone. High grade AV blocks are treated with IV ceftriaxone for 14-21 days, while first degree AV block is treated with oral antibiotics. Arthritis is treated with 30-60 days of oral antibiotics.

6) Should asymptomatic tick bites be treated?

There is some controversy regarding this topic. Although previous studies failed to show any benefit from prophylaxis, a study published in 2001 in the New England Journal of Medicine did show a benefit in patients who were given one dose of 200mg of doxycycline; patients treated had a confirmed (by an entomologist) Ixodes tick bite and presented within 72 hours of the bite. Treatment with the one dose of doxycycline had an 87% efficacy in preventing infection. In this study it was found that the incidence of lyme disease following a bite by an infected tick was 3.2% in the placebo group vs. 0.4% in the doxycycline treated group. The 2002 Sanford Guide To Antimicrobial Therapy recommends treatment if in an endemic area and the tick is partially engorged. As emergency physicians, patients that come to our departments and wait in our waiting rooms frequently have a high degree of apprehension regarding the their tick bite; the emotional benefit of one dose of antibiotics should be factored in to individual treatment decisions.

6) Should this patient be treated?

The patient in this case had a LP performed and the CSF was unremarkable (CSF was not sent for antibody testing although it could have been). His EKG was normal. The patient was treated with a 21-day course of doxycycline. Serum antibody tests results were positive for an antibody response to Borellia burgdorferi.

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Save the Date!

March 27, 2003

The Massachusetts College of Emergency Physicians and the Massachusetts Emergency Nurses Association (MENA) are pleased to announce that they will once again be holding their joint conference scheduled for **March 27, 2003**. The conference, the 10th of its kind, is planned at a new location, the Burlington Marriott, and will again provide the opportunity meet with your colleagues from many of the state's emergency departments while at the same time gaining current information on a variety of issues.

Included, among others in the CME program are Dr. Richard Westfall of NYC's St. Vincent's on disaster preparedness, Dr. Michael Shannon of Children's Hospital on the proposed smallpox vaccination of emergency personnel, and Dr. Michael Palmer of Physician Health Service regarding impaired physicians and nurses.

Be sure to look for the registration details in the upcoming mailed brochure, but in the mean time, mark your calendars.

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Case Management References:

Harwood-Nuss. The Clinical Practice Of Emergency Medicine. Third edition. Lippincott Williams & Wilkins 2001. Pages 907-912.

Rosen. Emergency Medicine Concepts and Clinical Practice. Volume 2. Mosby 1998. Pages 2348-2361.

Critical Decisions in Emergency Medicine. Volume 16, number 9, May 2002.

Nadelman RB et al. Prophylaxis with single dose doxycycline for the prevention of lyme disease after an Ixodes scapularis tick bite. New England Journal of Medicine 2001.

The Sanford Guide To Antimicrobial Therapy, 32nd edition, 2002. Pages 40-41.

MACEP Board Recertification Course Receives Rave Reviews

MACEP's Board Review Course was held this year from October 20-22 at the Boston Doubletree Guest Suites under the able guidance of Drs. Paul Janson and Julianne Huber. This was a second year for both co-directors and represented a return of many of our seasoned faculty along with some new faces. This year's course attracted 56 participants including 22 physicians from the state of Massachusetts as well as others from as far away as Manitoba, Australia, Hawaii and Iceland.

With 24 faculty members presenting solid information over the course of three days almost nonstop, those who needed to recertify or just brush up on their skills came away with a comprehensive overview of emergency medicine basics. That the course continues to be a success reflects on our outstanding faculty and their willingness to offer their skills to benefit MACEP.

Many thanks to: Drs. Cynthia Aaron, Brien Barnewolt, Marc Baskin, Jacques Blanchet, Mary Buechler, Kate Burke, John Cahill, Christopher Degnen, Michael Doyle, Stephen Epstein, Theresa Gabana, Donna Harkness, Richard Herman, Joseph Kahn, Neil Meehan, Matthew Mostofi, Mark Pearlmutter, Susan Torrey, Kenneth Williams and Alan Woodward and to Paul Janson and Julianne Huber whose attention to detail and long hours made this a success.

Membership Services Committee Looking for Volunteers

Dear Massachusetts Emergency Physician:

If you are interested in reshaping/enhancing the way in which the chapter serves its members, please consider joining the Membership Services Committee. We will try to meet in late December/early January, site to be determined. (Worcester is the frontrunner now based on geography.)

MACEP's 2002 Strategic Plan states the goal of Membership Services is "to recruit and retain members by providing value to their practice of emergency medicine." At our initial meeting, I would like to review how MACEP currently serves its membership and then gather ideas from the members on how this chapter committee can improve upon what we do.

This committee will also charged with the planning of future MACEP social events. Please email your reply to santasutt@attbi.com and also I am interested in suggestions on a suitable restaurant/watering hole for future meetings.

Brian Sutton, MD
Westfield, MA

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Calendar of Events 2002-2003

November 19
Board Meeting: 4:30 - 6:00
Roundtable Lecture: 6:00 - 7:00
Radisson Inn, Marlboro

December
No Meetings

January 21, 2003
Board Meeting: 4:30 - 6:00
Roundtable Lecture: 6:00 - 7:00
Radisson Inn, Marlboro

February 25, 2003
Board Meeting: 4:30 - 6:00
Radisson Inn, Marlboro

March 18, 2003
Board Meeting: 4:30 - 6:00
Roundtable Lecture: 6:00 - 7:00
Radisson Inn, Marlboro

March 27, 2003
MACEP/MENA Conference
Burlington Marriott

April 15, 2003
Board Meeting: 4:30 - 6:00
Radisson Inn, Marlboro

May 14, 2003
Annual Meeting
Waltham Doubletree

Board of Directors Meetings are held at the Radisson Inn, Marlboro. Members receive mailings to register for all programs, except for the Board Meetings and the Roundtable series. If you wish to attend the Board Meeting, call (781) 890-4407 or email sbeer@macep.org to reserve dinner. Pre-registration is required at all of our meetings, except the Roundtable series.

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