



MACEP News

October 2006 | Volume 32 | Number 3

President's Message

John C. Benanti, MD, FACEP



As everyone knows, Emergency Medicine is dealing with a number of major issues that affect our practice. I would like to discuss several in this newsletter.

On-Call Specialist Coverage

A recent ACEP Survey of Emergency Department Directors published in April of 2006 confirms the worrisome trend for hospitals and ED physicians as does the even more

recent IOM report on "The Future of Emergency Care in the United States Health System." The Survey findings "indicate that on-call coverage in the nation's Emergency Departments has deteriorated and public policymakers should take note of the largely unintended consequences of the changes made to regulations governing Emergency Medical Treatment and Active Labor Act." EMTALA is, for all intents and purposes, an unfunded mandate that requires Hospitals to evaluate, treat and stabilize all patients who arrive in the ED. It further states that a patient may not be transferred to another Hospital if, after all stabilizing efforts have been made, it is deemed that the patient's medical/surgical condition requires a "higher level of care" not available at the original Hospital. In this fashion, ED resources are being stretched to the breaking point as we now have fewer hospitals and markedly increased ED visits across the United States.

In the last 3 years, the Centers for Medicare and Medicaid have changed some of the rules and regulations for on-call consultants while recognizing the needs of the overcrowded ED. Consultants can now cover more than one hospital at a time and are increasingly limiting the amount of time they take call. A number of other factors, in particular the rising cost of liability insurance for specialists who cover emergency cases and the rising number of uninsured patients is greatly limiting access to care and specialty care in our EDs. Seventy-three percent of hospital Medical Directors reported inadequate on-call specialty coverage in 2005 compared to 66% in 2004. Hospitals of all sizes are affected and geographic location did not matter.

The most common specialty coverage issues presently are Neurosurgery, Orthopedics, Plastic Surgery, ENT and Hand Surgery. In addition, general surgeons who cover hospitals for

trauma are under the same time and commitment pressures. Many of these specialists continue to request shorter coverage hours and are negotiating on-call payment systems with those hospitals on which they are staff physicians. This places cost burdens on the entire healthcare system that is already under great financial stress. Thirty six percent of hospitals now have such arrangements, up from just eight percent in 2004.

Level I Trauma Center Directors noted that 10% of the transfers they received were felt to be inappropriate. That is, these patients could have been managed at the sending facility. In addition, over fifty percent of all patient transfers were made because the sending facility did not have timely availability of the on-call specialist. A similar trend is occurring among Level I Trauma Centers wherein transfers to another Level I Trauma Center become necessary due to unavailability of the specialist at the sending Trauma Center. The growing number of elderly patients who, when traumatized, are often more severely injured, will only increase this demand on our on-call specialists and on the overall healthcare system. The healthcare industry and those who control the payment system for doctors and Hospitals must recognize this spiraling problem and deal with it directly in the near future or the Emergency Medical System will be stressed beyond recovery in some areas and the "Safety Net" will be further threatened for the patients and communities we serve.

Psychiatric Emergencies in the ED

We have all noticed an ever-increasing number of patients requiring emergency evaluation and treatment related to substance-abuse and psychiatric disorders. These patients often require as much attention and due diligence in their management as the sick medical or surgical emergency patients who come through our doors.

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MACEP News

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Massachusetts College of Emergency Physicians

860 Winter Street
Waltham, MA 02451-1414
Telephone (781) 890-4407
Fax (781) 890-4109
www.macep.org

Susan Beer, Executive Director
sbeer@macep.org

Officers

President: John Benanti, MD, FACEP
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■ PRESIDENT CONT'D FROM COVER

The difference is that the psychiatric emergency patient is often with us for days at a time awaiting proper in-patient management of their myriad disorders. Psychiatric bed availability remains difficult at best for these patients. The time consumed for such placement is often inordinate and extremely taxing for our mental health staff (should you have this available to you) and to our Medical staff. These patients are at great risk for the reasons we are all too familiar with, especially those patients with substance abuse and recidivism after treatment. A recent article published in the New England Journal of Medicine revealed that 30% of all ED visits in Massachusetts were repeat patients, not first time users of the ED system. A large percent were in this category, further stressing our resources and ability to care for them in a timely and efficient manner.

MACEP, through the work of Drs. Mark Pearlmutter, Stephen Becker and RickHerman, has been working over the years in developing policies and procedures for managing these patients in our busy EDs. Concerns addressed have been proper Medical Screening and Clearance prior to transfer to an in-patient bed: for example, what tests are appropriate or required prior to acceptance at a treating facility; standardization of these test requirements for all facilities; appropriate use of Section 12s and Section 35s to help in management and treatment modalities for the safety of these patients and so on. Progress has been made in these areas but more needs to be done.

The Massachusetts Department of Public Health, Executive Office of Health and Human Services recently sent a document entitled "Practice Recommendations for the Emergency Department Care of Patients with Psychiatric Disorders and/or Behavioral Issues to Hospital CEOs, Directors of Emergency Services and Directors of Mental Health Services. This document attempts to "provide guidance to hospitals in the provision of care to patients with psychiatric disorders and/or behavioral issues in hospital Emergency Departments." ED physicians are urged to adopt these guidelines in their daily practice. These guidelines specifically address medical management and touch on the subject of proper use of restraints, chemical or physical. They are very helpful and well-constructed in this regard.

Unfortunately, they do not address the issue of length of stay in the ED setting and timely placement into an in-patient setting when deemed appropriate by hospital clinicians. These are the next set of guidelines we need to work on with our colleagues at MDPH, DMH and MHA. Working together with the known resources available in the Commonwealth, we should be able to better serve this population of patients. I am certain we can accomplish this goal as we all have the same goal in mind: the best possible care, provided in a Compassionate, Professional and Respectful (CPR) manner,

for all our citizens in the Commonwealth.

P.S.: Thank you to all those members who have volunteered to join our Committees this coming year. The Board of Directors and Committee Chairs look forward to your thoughts and ideas and active participation as we work on those items affecting our daily practice as Emergency Physicians. Your input will be much appreciated.



Welcome New Members!

- Annemieke Ateman, MD
- Steven Beckman
- Cathy Beland, MD
- Amir Bernaba, MD
- Evan Roy Berg, MD
- Ryan Carter, MD
- Alan Chang, MD
- Ann Cooper-Ciccarelli, DO
- Christopher Crean, MD
- Joseph Dundee
- Joshua Frank, MD
- Kevin Gentile, DO
- Katja Goldflam, MD
- Kevin Greer, MD
- Alexander Grinshpun, MD
- Emily Hayden, MD
- Maura Kennedy, MD
- Keli Mabbott Kwok, MD
- Alden Landry, MD
- Chris LeMaster, MD
- David Lindberg, MD
- Lukas Lolm, MD, FACEP
- Gina Lopez, MD
- Megan Leo, MD
- Andrew Liteplo, MD
- G. Michael Mahoney, MD
- Christopher McArdle, DO
- Hallie Mentz, MD
- Ward Myers, MD, MPH
- Lauren Nentwick, MD
- Helen Ouyang
- Jennifer Pope, MD
- Allsion Ramler, MD
- Vishnukrupa Reddy, MD
- Tricia Rotter, MD
- Melissa Rudolph, MD
- Raul Ruiz, MD
- Jeffrey Salerno, MD
- Nara Shin, MD
- Robert Sills, MD
- Gabriel Simon, MD
- Andrew Small, DO
- Frederick Thum, MD
- Charles Tuft, MD, FACEP
- Paradis Uychara, MD
- Michael Vortmann, MD
- Steven Yerid, MD



Legislative Summary

Ronna Wallace

With the end of the 2005/06 state legislative session upon us, its time to take stock of MACEP's track record over the last two years. Because it is an election year, formal legislative sessions ended on July 31st and will not resume until the 2007/08 session begins on January 3, 2007. The state legislature continues to meet informally, but can only act on non-controversial items.

As you know, Massachusetts became the first state in the nation this year to require its residents to purchase health insurance under Chapter 58 of the Acts of 2006. The new law aims to cover 95% percent of the 550,000 residents without insurance within three years through a combination of new insurance products, entitlement program expansions, public subsidies and cost control initiatives.

As a member of the Health Care for All "ACT Coalition" steering committee, MACEP was able to provide an Emergency Medicine perspective and input during the development of this law, and will continue to monitor the progress of the implementation by the Commonwealth Health Insurance Connector, the group charged with ensuring full compliance with legislative intent.

Over the past two years, MACEP members testified in favor of a number of bills that dealt with issues of public health and safety issues. Foremost among them was better access to emergency contraceptives and clean needles, both of which were signed into law. MACEP members also worked very diligently in support of the Primary Seat Belt law, one of emergency medicine's greatest disappointments this session. After coming closer than ever before by passing both the House and Senate, the bill was rejected when it was returned to the House on a traditionally routine enactment vote, something only used once in the legislature's past, effectively killing it until next year.

Legislative victories come in two forms – advancing good bills and stopping bad bills. It is the latter category that MACEP realized several "wins" this session. MACEP actively supported the Massachusetts Hospital Association's alternate wording of the Nurse Staffing bill, and opposed mandatory staffing ratios, as proposed by the Massachusetts Nurses Association. The MNA bill passed the House, and due to heavy lobbying was poised for action in the Senate. Fortunately, it was not voted on before the close of the formal session thus killing the issue for this session.

Another defensive victory was also scored with the defeat some legislation and several proposed budget amendments that would have required physicians to report treatment of minors suf-

"Legislative victories come in two forms – advancing good bills and stopping bad bills.

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fering from drug or alcohol abuse to law enforcement officials. MACEP will continue to look at this problem and will work to proposed better solutions than what those bills offered. In addition we testified against modifying an ambulance staffing bill that would have lessened the standards currently in place.

Last spring the Governor filed legislation to allocate \$35 million for the purchase of antiviral medication, ventilators and other medical equipment, and to ensure additional hospital bed capacity in case a deadly pandemic strikes. MACEP actively supported this legislation with oral testimony at the public hearing but offered revised language to indemnify and better protect physicians and others that volunteer in the event of a medical catastrophe. That bill is currently in House Ways & Means. Further action is uncertain this year.

So what is on the agenda for the next legislative session? Topping the list is finding a way to address the chronic problem of overcrowding by building on the findings in ACEP's *National Report Card on the State of Emergency Medicine*, and the Institute of Medicine's (IOM) report, *The Future of Emergency Care in the United States*, both of which identified overcrowding as a contributing factor to an overstrained emergency medical system, MACEP intends to take a proactive approach by filing legislation to address this problem with the hope of bringing the issue to the collective legislature's awareness. Additionally, the College will be convening an educational forum on overcrowding that we hope will bring a wider state-wide understanding of the problem through input from national and local experts, providers, hospitals, state government, and regional authorities.

Nurse staffing, preparedness, seat belts and other public health issues will remain a MACEP priority next year, as well as others to be determined in the fall. So stay tuned and stay active! Your support can make a difference!



Save the date!

More Than Ever, Come Together...in New Orleans!

For the
ACEP 37th Annual
Scientific Assembly

October 15-18, 2006

Registration now open:
(800) 477-ACEP
www.acep.org

Important Information from MACEP...

PLAN TO ATTEND FALL SEMINAR

MACEP is holding its day long Annual Fall Reimbursement and Coding Seminar on Friday, **November 17, 2006** at the Massachusetts Medical Society Conference Center in Waltham. The seminar covers critically important aspects of billing and coding and will help your practice optimize its financial bottom line. With the increasingly difficult coding and reimbursement challenges facing Emergency Medicine, the seminar is a must for physicians, coders and billing staff. To learn more go to MACEP's website www.macep.org or call (781) 890-4407. In addition, ACEP's Coding and Nomenclature Advisory Committee has recently developed several Pearls that are intended to help members understand some more common reimbursement topics. The Pearls are available on the ACEP reimbursement site: <http://www.acep.org/webportal/PracticeResources/issues/reimb/pearls.htm>. Members may also call the ACEP Reimbursement Department at (800) 798-1822 ext. 3233 or 3232 with any questions.

ROUNDTABLES RETURN

MACEP is pleased to announce a return of the Educational Roundtables under the direction of Co-Educational Chairs Drs. Matthew Mostofi and Luis Lobon. The first Roundtable is planned for **November 21, 2006** following the MACEP Board meeting on that date. The presentation "Understanding and Preventing Workplace Violence in the Emergency Department" will feature an overview of a recently prepared white paper by the Norfolk County District Attorney's Office and the Workplace Violence Prevention In Health Care Partnership that outlines the problem and offers practical guidelines for addressing it. The program is free to all members and will provide CME credit.

RISK MANAGEMENT REMINDER

Members who are covered by ProMutual are reminded that MACEP's web based Risk Management course is available at www.macep.org. ProMutual offers a malpractice discount for those who meet all their criteria and successfully pass the test associated with the course. That discount is only good for 4 years so anyone who has taken the course before July 2002 must take it again. The course can also be taken each year for the 6 hours of CME it offers.

CASE STUDIES WANTED

Do you have an interesting or unusual case study that you would like to share with your colleagues in the MACEP News? If so, contact Kalev.Freeman@BMC.org.

NEW DISASTER COMMITTEE FORMING

MACEP's newly formed Disaster Planning Committee will be hold its first meeting under the guidance of Dr. Joseph Bergen in order to develop a plan for MACEP's involvement in this critical area. The committee has been formed through discussions generated during the Retreat and Strategic Planning session, by the Board of Directors, and by the members of MACEP's Public Health Committee. The committee includes in addition to Dr. Bergen, Drs. Frank Friedman, Kimberly Markuns, Deborah Greene, Kathryn Brinsfield and Paul Paganelli. The meeting will be held prior to the next MACEP Board Meeting on October 24, 2006. Any member who is interested in becoming an active volunteer in this committee is urged to call (781) 890-4407 and to attend.

SIGN UP FOR MSAR

To improve the state's ability to act during a disaster or public health emergency and to prevent potential confusion among volunteers, the Massachusetts Department of Public Health has begun signing up physician and registered nurse volunteers in the Massachusetts System for Advance Registration of Volunteer Health Professionals (MSAR). To prevent confusion and to ensure there are skilled professionals available in the midst of disaster, it is important to identify, register, and pre-credential volunteers prior to such an event. All MSAR volunteers are required to complete successfully an online orientation training course that provides CME. Those volunteers will be placed on a list for the potential use of their skills in event of disaster or public health emergency. To learn more about the program go to www.mass.gov/MSAR or email msar@dph.state.ma.us.

COMMUNICATIONS UPDATE

MACEP Executive Committee under the guidance of Communications Committee Chair, Dr. Todd Thomsen, is pleased to announce they have recently selected a web-design company to evaluate and redesign MACEP's current website with the goal of better serving members. Dr. Thomsen who has ably chaired MACEP's Communications Committee for the past three years is stepping down from his position. MACEP is looking for someone to take over and to offer their guidance using both their medical and technical expertise as the redesigned website continues to grow and further meet member's needs. If you would like to learn more and are interested in volunteering, contact MACEP's Executive Director, Susan Beer at (781) 890-4407 or by email sbeer@macep.org.



Case Management

*“Altered Mental Status/Fever”
Jordan Spector, MD*

CC: Altered mental status and fever.

HPI: An 18-year-old male was transferred to the emergency department from a rehabilitation hospital for altered mentation and fever. The patient had been assaulted about the head with a bag of ice 7 days ago. The trauma had caused a left frontoparietal subarachnoid hemorrhage without skull fracture or midline shift. He had no other injuries and improved without neurosurgical intervention. His only medications had been haloperidol and lorazepam PRN for agitation. The patient had steadily improved since the event, and was described as alert, oriented, and ambulatory with assistance 5 days after the injury. His last CT scan, 2 days prior to the current presentation, showed near resolution of subarachnoid hemorrhage. On the day of presentation, the patient became gradually diaphoretic and difficult to arouse. He was found to be confused, febrile to 102.9 degrees Fahrenheit, and tachycardic. He was sent by ambulance to the emergency department for further evaluation. In the emergency department, the patient was somnolent but arousable. He complained only of severe thirst, requesting water repetitively.

ROS: Patient denied headache, chest pain, or abdominal pain. Limited by the patient’s altered mental status.

PMHx: None.

MEDS: Oxycodone/acetaminophen prn intermittent headache.

ALLERGIES: No known drug allergies.

SOCIAL HX: The patient smoked cigarettes and drank alcohol socially, prior to his head injury.

PHYSICAL EXAM

VITAL SIGNS: Temp 99.4 F, Pulse 143, BP 182/100, RR 20, 98% on RA.

GENERAL APPEARANCE: Thin male, lying with eyes closed and mouth open, arousable, lethargic, ill appearing.

HEAD/NECK: Normocephalic, no contusions, abrasions or lacerations, neck supple, normal ROM.

EENT: PERRL, EOMI, sclera WNL with subconjunctival hemorrhage in Rt eye. Nose, posterior pharynx and mouth normal, with dry mucus membranes.

HEART: Tachycardic, regular, no murmurs or rubs appreciated.

LUNGS: Clear bilaterally with good air movement.

ABDOMEN: Scaphoid, nontender, no distension, with voluntary guarding.

EXTREMITIES: No deformities, moderate to severe rigidity with passive ROM, no cogwheel rigidity, no cyanosis or edema, pulses 2+ at radial, DP/PT.

SKIN: Warm, normal color, diaphoretic.

NEUROLOGIC: Alert and oriented to person and “hospital”, cranial nerves II-XII intact grossly, no focal motor deficits, speech slurred, exam limited by poor cooperation.

STUDIES: Basic chemistries and cell counts were normal, with a WBC of 12 (76% PMNs). A serum toxicology was negative for acetaminophen, ethanol, tricyclics or salicylates. A urine toxicology sample was positive for opiates and amphetamines. His EKG was sinus tachycardia at 126 without evidence of conduction delay or dysrhythmia. A serum creatine phosphokinase (CK) level was 802. A CT scan of the brain showed small residual left sided intracranial blood without interval change. A lumbar puncture (LP) showed 1555 RBCs, and 6 WBCs, consistent with his previous subarachnoid hemorrhage. The CSF protein was 32, glucose was 82. Gram stain was negative.

ED COURSE: A neurologist service was consulted. The ED and consulting physicians felt the patient’s presentation was consistent with neuroleptic malignant syndrome (NMS), occurring as a result of the IV haloperidol he had received while recovering from the initial head injury. Antibiotics were considered but not given, as the LP results appeared inconsistent with an infectious process. The patient was started on bromocriptine and admitted to the medical intensive care unit (MICU).

HOSPITAL COURSE

In the MICU, the patient was continued on treatment for NMS, per neurology recommendations. He was given bromocriptine (2.5 mg PO every 4 hours) and benzotropine (1 mg IV twice a day). In the ensuing 3-4 days, he became less tachycardic and his sensorium improved. His laboratory studies were remarkable for a peak CK of 1050. He was transferred to a medical floor, with continued improvement of his mental status and his muscular rigidity. The patient would not consent for an MRI for further evaluation of his brain, and he was discharged to the rehabilitation facility in improved condition after 7 days.

QUESTIONS

What is NMS?

Neuroleptic malignant syndrome is a rare but potentially fatal neurologic disorder associated with the use of certain pharmacologic agents. The cause of NMS is not completely understood, though alterations in central dopaminergic transmission, serotonin transmission and autonomic activity appear to play central roles in the syndrome.

How does it present?

NMS classically presents with four clinical features: fever, muscle rigidity, altered mental status and autonomic instability. Hyperthermia is one of the most consistent features of NMS, with nearly 87% of patients presenting with fever to 38

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NMS at a Glance

Neuroleptic Malignant Syndrome is a rare, potentially fatal neurologic disorder associated with the use of certain pharmacologic agents. NMS classically presents with four clinical features:

- fever*
- muscle rigidity
- altered mental status
- autonomic instability

If NMS is suspected, a careful history with emphasis on recent medications (including OTC) is important. NMS can occur within 30 days of drug administration. In patients with mild symptoms, removal of the offending agent and supportive care are the mainstays of treatment. Most episodes resolve within 7-11 days. Current mortality estimates are 10-20%. Death is commonly from respiratory failure, cardiovascular collapse, renal failure, arrhythmia or venous thromboembolism. When promptly recognized and properly treated, patients will recover completely.

*Hypothermia is one of the most consistent features with nearly 87% of patients presenting with fever to 38 degrees Celsius.

■ CASE MGT CONT'D FROM PAGE FIVE

degrees Celsius. Mental status changes are variable, and range from delirium to coma. Dysautonomia manifests as tachycardia, hyper- or hypotension, and diaphoresis. Skeletal muscle rigidity is diffuse, and described as “lead pipe” rigidity for its stable resistance to all ranges of passive movement on physical exam. Laboratory findings associated with NMS include elevated CK, polymorphonuclear leukocytosis, and mild to moderate transaminitis. Serum magnesium, iron and calcium levels can be depressed. More advanced cases can develop rhabdomyolysis and associated renal failure. No laboratory test is pathognomonic for NMS.

What can cause NMS?

NMS is an idiosyncratic reaction to various drugs. When the condition was first described, the older (and higher potency) neuroleptics including haloperidol and fluphenazine were implicated. However the condition has been described in patients taking the newer “atypical” antipsychotic agents (clozapine, risperidone, and olanzapine) and in those taking phenothiazines (promethazine, metaclopromide). A

comparable condition has been described in Parkinsonian patients taking dopamine agonists who abruptly stop their medications. Risk factors for the development of NMS include recent initiation of treatment, recent increases in the dose of a medication, and use of a depot form of a neuroleptic. Some have suggested that parenteral administration of neuroleptics, concomitant lithium carbonate administration, psychomotor agitation, dehydration, and increased environmental temperatures predispose one to NMS, but this is not proven.

When entertaining the diagnosis of NMS, what other conditions are on the differential?

A number of toxin-induced hyperthermic syndromes (including malignant hyperthermia, serotonin syndrome and sympathomimetic ingestion) can present comparably to NMS. Malignant hyperthermia is a hereditary skeletal muscle disorder whereby patients respond to certain inhaled anesthetics and depolarizing neuromuscular blockers with rapid, profound hyperthermia and rigidity. Serotonin syndrome in particular can be difficult to distinguish from NMS. Given that many

patients are often treated with neuroleptics as well as selective serotonin reuptake inhibitors (an agent which can cause serotonin syndrome), it may be challenging to differentiate NMS from serotonin syndrome in a patient presenting with fever, altered mental status, and dysautonomia. Some have suggested that patients with serotonin syndrome usually present within 1 day of taking the offending agent, whereas NMS can occur within 30 days of drug administration. Further, serotonin syndrome induces a hyperreflexia, myoclonus and shivering that is absent in NMS. Serotonin syndrome often causes GI symptoms such as nausea, vomiting and diarrhea that do not occur in patients with NMS. CNS infections such as encephalitis and meningoencephalitis, seizures, heat stroke, tetanus, acute dystonia, thyrotoxicosis, CNS vasculitis, and certain withdrawal states can all mimic features of NMS as well.

What should I do in the ED if I suspect NMS?

A careful history, with emphasis on recent medications, including over-the-counter medications, is important. The managing clinician must avoid prescribing neuroleptics or phenothiazines to patients presenting with the classic symptoms. Primary survey should ensure respiratory and cardiovascular stability. Intravenous access should be obtained, and crystalloid should be administered. Laboratory testing should include blood counts, renal and liver function analysis and CK levels. A CT scan or MRI of the brain is necessary to determine whether symptoms are attributable to a structural etiology. An LP is indicated to evaluate for infectious processes. A neurology consult is appropriate when a patient has altered mental status and fever, and the imaging and LP are nondiagnostic. When the diagnosis of NMS is entertained, one ought to consult a toxicologist or the local poison control center.

How is NMS treated?

In patients with mild symptoms, removal of the offending agent and supportive care are the mainstays of treatment. Support-



ive measures include external cooling techniques, volume resuscitation and electrolyte repletion. In patients with severe symptoms, including severe hyperthermia, coma and rhabdomyolysis, mechanical ventilation may be required. Initiation of medical treatment is indicated for severe cases. Dantrolene is a drug that functions as a skeletal muscle relaxant, and is often administered to those in whom NMS is suspected. It can be given parenterally at a dose of 3 to 5 mg/kg, divided three times a day. Dantrolene can cause hepatocellular toxicity, and should be avoided in those with abnormal liver function tests. Bromocriptine is a centrally acting dopamine agonist, and is dosed at 2.5 mg PO (or via nasogastric tube in intubated patients) every 4 to 6 hours, titrated to a maximum dose of 40 mg per day. Bromocriptine has been given to patients along with dantrolene, in certain instances. Amantadine is an agent with dopamine agonist properties, and can be prescribed instead

of bromocriptine. It must be noted that there is no strong evidence to support the use of any one treatment agent over another. However, with the high morbidity and mortality associated with NMS, patients with severe symptoms require medications. Finally, benzo-diazepenes can be of value to treat delirium and catatonia.

What is the prognosis?

When a physician suspects a patient has NMS, disposition to an intensive care unit is appropriate. Most episodes of NMS resolve within 7-11 days. In the 1980s, mortality estimates were as high as 20-30%, though current mortality estimates are 10-20%. Death is commonly from respiratory failure, cardiovascular collapse, renal failure, arrhythmia, or venous thromboembolism. When promptly recognized and properly treated, patients will completely recover from NMS.



NMS REFERENCES

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Employment Opportunities

BOSTON - F/T Pediatric EM academic faculty position at Tufts-New England Medical Center and The Floating Hospital for Children, the principal teaching hospital for Tufts University School of Medicine in Boston. Must be BC/BP in Pediatric EM or have dual residency training in pediatrics and EM. Outstanding research and teaching opportunities working with medical students, pediatric and EM residents. ACS Level 1 Pediatric Trauma Center, 40,000 visits/year in a state of the art facility with dedicated Pediatric area, pediatric nursing and Child Life services in the Department. T-NEMC is one of twelve Agency for Healthcare Research and Quality (AHRQ) Evidence-based Practice Centers and is one of only two designated U.S. Cochrane Centers. Academic appointments in EM and Pediatrics. Contact Brien Barnewolt, MD, Chairman, T-NEMC, Dept of Emergency Medicine #311, 750 Washington Street, Boston, MA 02111, (617) 636-4720, bbarnewolt@tufts-nemc.org.

BURLINGTON - The Department of Emergency Medicine at Lahey Clinic Medical Center seeks full-time Senior Staff Emergency Physicians. Lahey Clinic is an ACS verified Level II Trauma Center and sees 36,000 patients annually. The Department currently has 14 full-time physicians with 22 beds and plans for expansion. Candidates must be BC/BE with preferably 2 or more years experience. Lahey Clinic Medical Center is a teaching hospital for Tufts University School of Medicine. In addition, many of our physicians hold teaching assignments at Harvard Medical School and Boston University School of Medicine. The Clinic maintains residency and fellowship programs for more than 130 new physicians in multiple subspecialties. Call (781) 744-2864 or email yvette.drinkwater@lahey.org or malcom.a.creighton@lahey.org.

CONCORD - P/T work w/ a well-trained, very stable EP group and ED staff. Emerson Hospital Emergency Physicians seeks P/T board certified EPs who will not be expected to work night shifts, but who are willing to work weekends, holidays, and normal weekday shifts. With an annual visit volume of 34,000 patients (treated in our 15-bed main department and 6-bed urgent care areas) we are committed to providing high-quality emergency care. We invite you to send your curriculum vitae and/or contact Joseph M. Bergen, DO, Chairman of Emergency Services, Emerson Hospital, 133 ORNAC, Concord, MA 01742. Phone: 978-287-3697, Fax: 978-287-3674 or email: jbergen@emersonhosp.org.

SALEM - North Shore Medical Center Emergency Services, a member of Partners HealthCare System, Inc. (which includes founding members Brigham and Women's Hospital and Mass General Hospital), is seeking full-time BC/BE emergency physicians. Join a 19 member democratic and stable group with excellent medical staff back up. Flexible shifts available, particular interest in MDs who are looking for exclusive night shift commitment. Excellent compensation (including incentive compensation) and comprehensive benefits. North Shore Medical Center is located 15 miles north of Boston and convenient to many exceptional cultural, educational, and recreational activities. For more information, contact Louis Caligiuri at 978-354-2581 or lcaligiuri@partners.org.



Calendar of Events

2006-2007

October 15-18, 2006

ACEP 37th Annual
Scientific Assembly
New Orleans

October 24, 2006

MACEP Open Board Meeting
Marlboro Courtyard by Marriott
4:30 - 6:30 pm

November 17, 2006

MACEP Annual Reimbursement
and Coding Conference
MMS Conference Center
Waltham, MA

November 21, 2006

MACEP Open Board Meeting
and Educational Roundtable
Marlboro Courtyard by Marriott
4:30 - 6:30 pm

December 2006

NO MEETING

January 23, 2007

MACEP Open Board Meeting
Marlboro Courtyard by Marriott
4:30 - 6:30 pm

February 27, 2007

MACEP Open Board Meeting
Marlboro Courtyard by Marriott
4:30 - 6:30 pm

March 20, 2007

MACEP Open Board Meeting
Marlboro Courtyard by Marriott
4:30 - 6:30 pm

April 24, 2007

MACEP Open Board Meeting
Marlboro Courtyard by Marriott
4:30 - 6:30 pm

May 9, 2007

MACEP Annual Meeting
MMS Conference Center

*For more information,
about any of these
upcoming events,
please call MACEP at
(781) 890-4407 or
visit our website at
www.macep.org.*

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