# MCEP News & Views

ADVANCING EMERGENCY CARE

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Submissions to the March/April Newsletter should be received by the Chapter office no later than March 20, 2017.

# FROM THE PRESIDENT

*Larisa Traill, MD, FACEP*

Thank you again to everyone who made it up to our Winter Conference. For those members who would like an update on what your MCEP Board is doing to you please see our electronic newsletter in which I have provided a brief summary of our January meeting. In this issue, as a follow up to my previous column and in deference to ACEP's recent physician wellness week, I would like to elaborate a little further on the state of the health of physicians in our specialty and how we can tackle this issue going forward.

The wellness of a person can be defined not only by the absence of disease and infirmity, but also by the presence of a state of complete physical, psychological, and social wellbeing. Despite the fact that overall, physicians have been found to have healthier lifestyles and generally live longer than the population at large, professional dissatisfaction has doubled in the last few decades. Physicians have a higher rate of depression and a much higher rate of suicide than non-physicians. In fact, 300 to 400 physicians die each year from suicide–that's one a day (the equivalent of two large medical school classes). Female physicians are 2.3 times more likely to die by suicide than those in the general population; male physicians, 1.4 times more likely. Suggested explanations include a higher prevalence of psychiatric disorders among physicians, such as drug and alcohol abuse and a tendency not only to neglect the need for psychiatric, emotional, or medical help, but also to poorly recognize the early signs of stress and/or burnout.

The term "burnout" has rapidly moved from colloquial speech into the vernacular to describe a condition marked by emotional exhaustion and negative or cynical attitudes towards others and oneself. Burnout as a syndrome is characterized by severe emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment. Unlike major depressive disorder, which pervades all aspects of a person's life, burnout is a distinct work-related syndrome and is most likely to occur in jobs that require extensive care of other people and prolonged involvement in situations that are emotionally demanding, thereby rendering emergency physicians particularly at risk. While the condition is not exclusive to emergency medicine, or medicine as a whole, our specialty inherently possesses many of those factors that contribute to burnout, including: unclear or impossible requirements, high stress with few or no "down" times, serious consequences for failures, lack of personal control, lack of recognition, poor communication, and often poor leadership. Furthermore, personality traits most highly correlated to burnout are just those naturally suited to the emergency medicine: perfectionist, high achieving, controlling, and type A. The strongest predictor of career burnout was the high anxiety caused by concern for bad outcomes and emergency physicians were found to have a poor tolerance for uncertainty only as it pertained to bad outcomes. It is important to differentiate burnout from stress: The former is characterized by disengagement, blunted emotions, loss of motivation, and depression, whereas the latter is exemplified by over-engagement, overactive emotions, hyperactivity, and anxiety disorders. And so, while burnout results in primarily emotional damage and will make you feel like life isn't worth living, stress results in primarily physical damage and will kill you prematurely. According to *Medscape Emergency Medicine Lifestyle Report 2016: Bias and Burnout* by Carol Peckham, *January 13, 2016*, Emergency Medicine is behind only Critical Care and Urology in burnout, ahead of 22 other specialties surveyed. The same survey sited female physicians as slightly more burned-out than their male counterparts and top reasons for burnout were: too many bureaucratic tasks, followed by too many hours at work and increasing computerization. On a positive note, despite being one of the least happy specialties while at work (5th from the bottom), emergency physicians were the fifth happiest specialty outside of work, behind nephrology, dermatology, pulmonary medicine, pediatrics, and psychiatry.

Much of the chronic distress physicians experience is due to the culture of medical education and practice, the nature of our work, and stresses imposed by the current health care environment. We are supposed to see more patients in less time and provide much more documentation. We work daily with human tragedy, illness, death, and loss. Many of us don't take time off or debrief after adverse events or patient deaths. Instead, we move on to the next patient. It's no wonder that more than half of physicians report being burned out. Even more worrisome, most physicians suffering from burnout or depression don't seek treatment and, undeniably, the quality of patients' treatments are ultimately affected.

Although we should know better, physicians have longstanding internalized stigma about mental health treatment, believing that it represents weakness and vulnerability. Beginning in medical school, physicians in training tend to avoid mental health treatment because of fears about privacy, confidentiality, and how it might affect their future careers. These attitudes persist, and even strengthen, through physicians' careers. We must de-stigmatize seeking help and provide physicians with prompt and targeted mental health assessments, support, and treatment. Lastly, we must work to prevent burnout and depression by removing barriers such as intensely busy work schedules, the cost of mental health treatment, and the difficulty of finding resources even afterhours.

Physicians should be guided from the earliest years of training to cultivate methods of personal renewal emotional self-awareness, connection with social support systems, and a sense of mastery and meaning in their work. Many departments have developed initiatives to address physician wellness by establishing wellness committees and mentor programs in which senior clinicians guide and support junior members in their career development and in balancing their personal and professional lives. There are also departments with confidential support groups, annual well-being retreats, fitness center memberships, contracts requiring all physicians have their own primary care physician, sabbatical programs, and flexible scheduling. I encourage you all to read the book *"Physician Suicide Letters Answered"* by Dr. Pamela Wible; book proceeds will be used to humanize the medical education system, thereby saving the lives of suicidal medical students, residents, and physicians. §

# ACA REPEAL = A COLOSSAL AMBIGUITY

*Gregory Gafni-Pappas, DO, FACEP*

Republicans have made it clear that they intend to repeal the Affordable Care Act (ACA). Now with Trump's recent executive order to "ease the burden of Obamacare" and Price confirmed as the secretary of the Department of Health and Human Services, it seems sure that some sort of repeal will be successful.

But what does this mean for the house of medicine and more specifically, emergency medicine in the state of Michigan? Since the ACA was adopted, Michigan's uninsured has dropped to 600,000 from 1.2 million. Many of us have noticed a significant increase in insured patients in our Emergency Departments as well as increased volumes throughout the state. Yet with more insured patients including those with pre-existing conditions, insurance premiums have also skyrocketed. Though no one knows exactly what changes are to come, there are some certainties and some speculation that will come from these changes. While Obama prioritized providing insurance for low income families and those with health problems, Trump's administration will have a different agenda of deregulation, reducing taxes, transferring responsibility for health coverage to state lawmakers, and increasing marketplace competition.

Deregulation takes time and can create instability without proper strategies to handle the downstream affects of these changes. In the coming year, it is unlikely that changes will be quick, as this could cause as many as 20-30 million people in this country to lose insurance coverage, including up to 600,000 in Michigan. However, to ease the burden on insurance companies from such ACA requirements as paying for pre-existing conditions, Trump may allow insurance companies over the next year to use hardship waivers for the individual mandate. This could lead to fewer covered drugs or even caps on visits. Even more, Trump's administration has announced that he may not even enforce the individual health insurance mandate, which could further increase the number of uninsured patients. There is certainly the possibility to see higher numbers of uninsured patients in our EDs in the next year but it is still unlikely to occur quickly. Eventually experts say the individual mandate will be removed completely, which could put more financial stress on hospitals and EDs by increasing the uninsured pool.

To reduce taxes, Trump plans to change the tax code to allow individuals to deduct health insurance premiums and plans to expand health savings accounts (HSA) that are tax-free. It is unlikely that this will reduce overall individual and family health care expenses alone without other reforms to decrease global health care costs. However, this could be a nice benefit for physicians paying high premiums for insurance, assuming the rule allows deductions at physician income levels.

Republicans have long argued that the states should have more say in their resident's health care coverage. In order to do this, Trump and Congress could propose that Medicaid be transformed into block grants to the states. Some say this would allow states to determine how the money is used and encourage lawmakers to reduce waste to save the federal government billions of dollars. Critics however say that this will cause Medicaid money to be cut over time if the program fails to keep up with rising healthcare costs. In Michigan alone, this could mean less coverage for Medicaid enrollees. Governor Rick Snyder is among republican governors that are pushing to keep Medicaid Expansion to help residents in our state gain access to healthcare.

Finally, one of Trump's major moves would be to encourage marketplace competition to challenge insurers, health systems, and healthcare providers to deliver higher quality care for a lower price. One way legislators may do this is to allow health insurance to be sold across state lines. Another idea is to allow medications to be imported, creating competition in drug pricing. Our lawmakers may also ensure price transparency for medical procedures and other healthcare costs. Either way, whether or not you believe that competition creates better more affordable care, this will likely be knocking on your door in the near future.

A number of republican replacement bills are currently being developed and debated on the hill. Key themes and questions are certainly politically charged; what to do with Medicaid expansion, how to develop and fund high-risk pools for patients with pre-existing conditions, how to provide tax credits and who should receive those credits, and many more topics. Preventative services and contraceptive access will also likely decrease, with the potential to impact women's health. However, it does appear that many lawmakers including Trump would like to see some form of continued insurance for pre-existing conditions – though most likely with higher insurance costs, as well as young adults to be covered by their parent's insurance up to 26 years old, both important features of the ACA.

We will be navigating unchartered territory over the next 4 years. But one thing is certain; we will continue to fight for our patients to provide them the outstanding emergency care that they deserve. §

## 2017 BOARD ELECTIONS

All active members of the Michigan College of Emergency Physicians interested in serving on the Board of Directors are encouraged to submit their names to the 2017 Board Nominating Committee for consideration as the Committee develops the slate of candidates. New Board members will be selected at the Michigan Emergency Medicine Assembly to be held at the beautiful Grand Hotel at the end of July. **Four** 3-year posts on the Board are open for election this year.

Those interested in Board service should e-mail or fax their notice of intention to the Chapter office no later than **March 1, 2017.** Please include with your notice a brief biographical sketch, a copy of your curriculum vitae, and your preferred contact information. Thank you! §

# REIMBURSEMENT CORNER

Now that 2017 is here it's a good time to review what MACRA and MIPS mean for emergency physicians. The **M**edicare **A**ccess and **C**HIP **R**eathorization **A**ct was bipartisan legislation passed in 2015 that ended the Sustainable Growth Rate (SGR) formula. MACRA ushers in the era of pay-for-performance gradually replacing fee-for-service Medicare reimbursement. Payment will be based on quality, not quantity. There will be small inflationary adjustments to reimbursement of 0.5% yearly through 2019 only.

There are two different programs, the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). APMs have to be CMS approved and at this point in time there are none that include emergency medicine meaningfully. APMs have the potential of paying a 5% uptick and may be more popular as they are better understood for our specialty.

MIPS combines 3 current quality programs - PQRS, Meaningful Use, and Value-based Payment Modifier. These become Quality, Advancing Care Info (ACI), and Cost. MIPS then adds one new program - Improvement Activities (IA).

MIPS takes a winner and losers approach to future payment adjustments as it is a zero sum game, i.e. budget neutral. Maximum incentives will be 4% in 2019 increasing yearly until 9% in 2022. There will be corresponding penalties. Clinicians will be scored with high performers getting the incentive and low performers getting penalties. The penalty money is used to pay the incentive. There will be a separate $500 million pool to bonus exceptional performers. 2017 data will be used to calculate 2019 reimbursement. Since minimal reporting is required in 2017, it is thought there will be small penalties (much less than 4%) and therefore small incentives.

Individual MIPS scores will be published for the public. Medicare providers will be rated from 1 to 100 comparing them to other providers. An individual MIPS score is retained by a clinician even if changing practices until the next reporting period. Will groups use this on provider scorecards and will it affect recruiting?

MIPS scoring assigns weighting factors to each of four categories (Quality, Improvement, Advancing Care, and Cost) and then scores individual performance in each. The combined weighted scores become your composite score. Quality is weighted 85% in 2017 with Improvement Activities weighted at 15%. Advancing Care Info and Cost are 0% in 2017. These shift yearly and by 2019 Quality will be 30%, IA still %15, ACI 25%, and Cost 30%.

**Quality** replaces the PQRS system by scoring clinicians on 6 quality measures with one being an outcome measure. There are 8 suggested EM Quality measures – Care Plan, Prevention of central line infections, Acute otitis externa topical therapy, Acute OE systemic therapy avoidance, Tobacco use prevention, US for pregnant patients with abdominal pain, High BP screening, and ED utilization of head CT for minor adult head trauma. None of these qualify as outcome measures.

**Improvement Activities** involves choosing clinical practice improvement activities from a list of 90. **Advancing Care Information** will be based on relative performance on selected measures related to the electronic health record. It is not weighted in 2017. **Cost** has no reporting requirements for clinicians but rather will be calculated by CMS. Cost has 0% weighting in 2017.

*Warren Lanphear, MD, FACEP*

Successful MIPS participation entails choosing activities wisely and completing them consistently. For 2017, groups can implement participation at varying levels, from no data submitted (4% penalty) to reporting one measure (no penalty), partial data from 90 days (neutral or possible small reward) to full participation (moderate reward).

The Clinical Emergency Data Registry (CEDR) developed by ACEP will be an important tool for accurately reporting quality data and may count for the Advancing Clinical Information portion of MIPs as well. CEDR is accountable, secure, and cost-effective. Groups and individual physicians can query the data and make informed choices for their reporting. A group may choose to report different measures for individual physicians based on their unique score.

Your employer or group should be taking action now to implement MIPS participation for 2017. Pay attention to the Quality measures and Improvement Activities selected. It will become increasingly important each year to understand what is required so as to maximize your Medicare reimbursement. Since this is really a zero sum game, your efforts will at best protect current revenue. §

*Thank you to Tammy Munger from Medical Management Specialists for her assistance and also to Zotec Partners for use of their background material.*

## MAP CHANGES

The State of Michigan will be replacing the Michigan Automated Prescription System (MAPS) with Appriss, PMP AWARxE software.

*Key Dates to Remember*

March 9, 2017: PMP AWARxE registration available for new MAPS platform.

April 3, 2017: Last day to submit requests and/or file submissions to the existing MAPS.

April 4, 2017: All requests and reporting must go through the new system. Current MAPS accounts will no longer be accessible.

*Important Information*

Accounts from the current MAPS will not be transferred to the new system.

Beginning March 9, 2017, pre-registration to PMP AWARxE will open to setup your new MAPS account.

All requests and reporting will be made to the current system through April 3, 2017.

Should you have any questions, please contact the MAPS support team at (517) 373-1737 or email at BPL-MAPS@michigan.gov<http://trk.appriss.com/jUSP023jU00ae0EOQdD0l00>.

# MCEP RECOGNITION OF GROUPS/EMERGENCY DEPARTMENTS WITH 100% MCEP MEMBERSHIP

The Michigan College of Emergency Physicians is again proud to recognize emergency groups and departments that have 100% MCEP membership.

MCEP will reward physician groups/hospitals with 100% participation in MCEP with the following considerations: publication of the name of your group/hospital in News & Views and a membership plaque suitable for display, along with a framed certificate for each ED staffed by the group. Those continuing their 100% MCEP membership will receive a brass plate with the current year to be added to the original display plaque. All awards will be presented at the Presidents' Banquet taking place during MCEP's Annual Michigan Emergency Medicine Assembly. This year's Assembly is scheduled for July 30 - August 2, 2017 at the beautiful Grand Hotel on Mackinac Island.

Please forward the name of your emergency physicians, the name of your group, and name of your hospital emergency department(s) to the Chapter office by fax, (517) 327-7530 or by e-mail to mcep@mcep.org by **June 1, 2017**. §

# LEGISLATIVE COLUMN

The 99th Michigan Legislative Session began officially on January 11th. Governor Snyder gave his seventh State of the State on January 17th and the House of Representatives named their committees in late January. All that's missing from the traditional start of the Lansing legislative cycle is the state budget address – which will take place on Wednesday, February 8th.

During all the pomp and circumstance of the beginning of session, bills are being introduced in each chamber on session days. MCEP is already tracking multiple bills affecting College members. Below is a list of a few bills impacting MCEP members.

SB 33, sponsored by GOP Senator Ken Horn of Saginaw, is an MCEP priority that increases penalties on individuals assaulting hospital personnel in the emergency department. MCEP Legislative Chair Dr. Rami Khoury testified in the Senate Regulatory Reform Committee in support of the bill in late January. The bill was reported from Committee and now awaits action before the whole Senate.

GOP Representative Edward Canfield (Sebewaing) introduced House Bills 4134 and 4135, with the legislation calling for the prohibition of insurance companies from basing a physician's participation in the company solely on whether said doctor took the national re-certification exams. This is a priority of MSMS and MCEP was active with the bills last session. Rep Canfield, a D.O. for several decades, was recently selected as the House Appropriations Subcommittee on DHHS Chair by Speaker Tom Leonard and will be establishing spending priorities for DHHS for the next two budget cycles.

Numerous bills have already been introduced on the subject of opioids. MCEP is active on all of those bills and has been working with the state on the roll out of the updates to the MAPS program, which is slated to take place in early April.

Lastly, I alluded to the naming of new committees for the House. Below is the list for the House Health Policy Committee with their party affiliation and hometown. If you have an existing relationship with any of these members, please let MCEP know so we can begin a dialogue with you and the committee member. Politics usually produce the best results when they start locally.

**Health Policy**
Hank Vaupel (R) Committee Chair, (Fowlerville)
Jim Tedder (R) Majority Vice-Chair, (Clarkston)
Joseph Graves (R) (Linden)
Daniela Garcia (R) 90th District (Holland)
Jason Sheppard (R) (Lambertville)
Julie Calley (R) (Portland)
Diana Farrington (R) (Utica)
Roger Hauck (R) (Mt. Pleasant)
Pamela Hornberger (R) (Chesterfield Twp)
Bronna Kahle (R) (Adrian)
Jeff Noble (R) (Plymouth)
Winnie Brinks (D) MVC, (Grand Rapids)
Andy Schor (D) (Lansing)
LaTanya Garrett (D) (Detroit)
Sheldon Neeley (D) (Flint)
Abdullah Hammoud (D) (Dearborn)
Kevin Hertel (D) (St. Claire Shores)

Please feel free to reach out to Dr. Rami Khoury, Chair of MCEP's Legislative Committee, or Bret Marr with any questions you may have on state legislative or regulatory issues. §

*Bret Marr, Lobbyist*
*Muchmore, Harrington, Smalley & Associates*

www.mcep.org

# THE MEDICAL STUDENT LEADERSHIP INITIATIVE: FOUR YEARS IN REFLECTION

*By: Jacob Manteuffel, MD, FACEP*

In the spring of 2012, Dr. Anthony Bonfiglio, MCEP's president at the time, and our Executive Director Diane Bollman asked me if I was interested in pursuing a medical student leadership initiative on behalf of MCEP. The opportunity was a natural fit for me with my interests in organized emergency medicine and my ties to undergraduate medical education as emergency medicine clerkship director at Henry Ford Hospital in Detroit. I had already been giving short lectures and presentations to our residency regarding organized emergency medicine and with a little fine tuning, directing the talk towards medical students, I began visiting the emergency medicine interest groups (EMIGs) at each of the medical schools in the state of Michigan in the fall of 2012. I gave talks to the EMIGs at the University of Michigan, Michigan State University (MD and DO programs) and Wayne State University. The medical school at Oakland University was in its infancy and was not yet on my radar and the medical schools at Central Michigan University and Western Michigan University did not exist. I was encouraged by the number of students who attended these talks voluntarily and impressed by the level of engagement of these students. I met Dr. Zachary Jarou at an ACEP residency fair in the fall and he served as the host for my visit to Michigan State University EMIG. In the spring of 2013, Dr. Jarou was appointed to the role as Chair of the MCEP Medical Student Council (MSC), modeled after the MSC of the Texas College of Emergency Physicians. The structure of our MSC took shape with Co-chairs and a Secretary of the council along with designated Liaisons and Representatives from each medical school's EMIG to the MSC. The Co-chairs, the Secretary, Liaisons, Representatives, and all other interested students effectively comprised the group known as the MCEP MSC, with myself serving as the Faculty Advisor and Diane Bollman as the Chief Executive.



Our main goal in that first year was to organize our first annual meeting, the Medical Student Forum, in conjunction with the MCEP Winter Symposium at Boyne Mountain. The idea was to have students convene at a venue where they could interact informally with emergency medicine physicians both in and out of the conference, have some student specific programming, and to network amongst each other with some of their EMIG best practices. We had a successful Forum at the end of January, 2014 with over 30 students. The leadership positions have changed, but the student engagement has remained strong and we expanded our Forum in 2015 and 2016 to over 50 students. In our most recent Medical Student Forum at the end of January, 2016, students were able to interact informally with MCEP physicians at our opening reception. The next morning after a brief introduction to organized emergency medicine, students split into 2 groups. One group consisted of small group advising regarding emergency medicine rotations, residency applications, the match process, and the specialty in general. The other group experienced hands on training with ultrasound, airway management and interosseous catheter placement. The groups switched halfway through the morning. Dr. David Overton followed with his ever popular "Diff'rent Strokes" lecture on residency program comparisons. This was followed by the MSC leadership meeting and an EMIG best practice sharing session. Students were able to take in the Winter Symposium the next morning, or participate in an instructional session with the Boyne Mountain Ski Patrol. We were fortunate enough to have the Medical Student Forum be sponsored by EMRA, Arrow (EZ-IO), and the residency programs from Beaumont, Sparrow (MSU), Central Michigan, and Henry Ford (Detroit).

The MCEP MSC serves also as a Legislative Action Network, connecting all students interested in Emergency Medicine across the state and allowing information to be disseminated quickly when needed. Plans of MSC this year include a residency fair, co-sponsored with the Ohio Chapter of ACEP to be held in the spring of 2017. A facebook page for the MSC has recently been started, www.facebook.com/MCEPMedicalStudents, with plans to feature MCEP events to medical students and allow them to arrange transportation and room sharing at our Medical Student Forum.

Thus far, I have visited and spoke to EMIGs at 6 of the 7 medical schools in the state and I continue to be very impressed with the engagement and interest amongst medical students since this initiative began in 2012. I try to visit each school every other year. Strong student leadership has been the key to the sustenance and growth of this group. I look forward to another successful year with this year's co-Chairs, Teimojian Tan (MSUCOM) and Kasey Mckay (CMU) along with our secretary, Robert McDaniels (MSUCOM). Now in our 5th academic year of this initiative, the first students involved in the initiative will be graduating from residency and continue their engagement and leadership within our specialty. §

# PHYSICIANS/POSITIONS AVAILABLE

**KALAMAZOO, MI:** We are hiring NOW. Growing-yet established-democratic group offering competitive benefit and preeminent shareholder package and sign-on bonus. Offering self-regulated schedule, APP coverage, specialty back up coverage. Foster your academic interests with teaching and research opportunities through Western Michigan University Homer Stryker M.D. School of Medicine. Looking for Board Certified/Board Eligible Emergency Medicine Physicians/Residents interested in partnership opportunity where you will share in ownership and our vision for continued growth in our region. Full time, permanent positions for hospitals from rural single coverage to Southwest Michigan's only Level 1 Trauma Center. Kalamazoo is a vibrant, cultural community with excellent school districts and professional opportunities for partners/spouses. Settled among inland lakes and only two hours from Detroit and Chicago. Email CV to corporate@swmes.com attention President. [6-5]

**MEDICAL DIRECTOR, SOUTHWESTERN, MI:** Kalamazoo Emergency Associates, PLC, an established democratic group providing Emergency Care in Kalamazoo, MI, Plainwell, MI, Marshall, MI and Portage, MI is seeking Board Certified or Board Prepared Emergency Physicians. Experience in Emergency Medicine Leadership/Directorship a plus. Partnership opportunities available. For qualified applicants please forward CV to kea@borgess.com attention Sara Buchanan. [3-3]

**PHYSICIAN HEALTHCARE NETWORK/MCLAREN PORT HURON:** Physician HealthCare Network's Emergency Medicine Department is offering a career opportunity that provides the option to work in a diverse practice environment, seeing a higher level of acuity and treating a more rural patient population at McLaren Port Huron Emergency Center. Physician HealthCare Network, PC, is a Multi-Specialty Group based in Port Huron, MI that is physician owned, offering a wide variety of services to the community. McLaren Port Huron Hospital is a 186 bed not-for-profit facility treating nearly 42,000 emergency room patient visits a year. You will have the opportunity of a partnership track position with excellent compensation and bonus potential, a robust profit sharing/401k participation, comprehensive benefits, pleasing work environment with outstanding staff and physician assistant support, a variety of shift options and strong collaboration with your partners. With its location on Lake Huron and the St. Clair River, Port Huron offers sandy beaches, friendly parks, convenient marinas along with beautiful scenery. Port Huron provides easy access to major airports and the metro Detroit area: including the arts, fine dining and many major sports teams. Interested candidates please contact: Todd Dillon 314-236-4496 tdillon@cejkasearch.com [5-4]

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*By: Jeffery McGowan, DO and Mary Hughes, DO, FACEP of the MSU/Sparrow Emergency Medicine Residency Program, Lansing, MI.*

# 58 YEAR OLD MALE WITH A RED EYE AND BLURRY VISION

**Introduction/Presentation:**

A 58 year old caucasian male presented to the ED with right eye redness and injury that occurred 2 weeks ago while using an acetylene torch to cut a metal bolt. He noted that he felt pieces go around his right eye. He was wearing safety glasses but took them off to rub the right eye. Symptoms began with eye redness but no discomfort or any visual complaints. He was seen by an optometrist 10 days after the initial injury, 4 days prior to initial ED visit, because he noted some photophobia and his eye was more irritated. He was started on tobradex (tobramycin/dexamethasone) drops with planned optometry follow up. The next day on follow up he had worsening symptoms with new onset "blurry and foggy vision," so he was referred to an ophthalmologist. The ophthalmologist stopped the tobradex and switched him to ofloxacin, homatropine, and durezol drops. He was seen again on the day of his ED visit with continued redness, eyelid swelling, mild discomfort, and worsening blurry vision of the right eye. His last tetanus immunization was more than 10 years prior. His past medical history included diabetes type II (well controlled – last HgbA1c 7.1), hypertension (well controlled), and hyperlipidemia. His medications included aspirin 81 mg QD, Vitamin D, metformin 1000 mg BID, lisinopril 40 mg BID, hydrochlorothiazide 25 mg QD, and lipitor 80 mg QD. He had no known drug allergies. His social historty included tobacco use, occasional alcohol, and he denied illicit drug use. He had no previous eye injuries.

Physical exam findings included stable vitals with a grossly normal exam besides the detailed eye exam below.

Visual acuity: Right 20/200, Left 20/40, Both 20/25

Intraocular pressures: Right 29 and Left 21

Eyelids: Right upper and lower lid edema

Conjunctiva/sclera: Right with significant injection

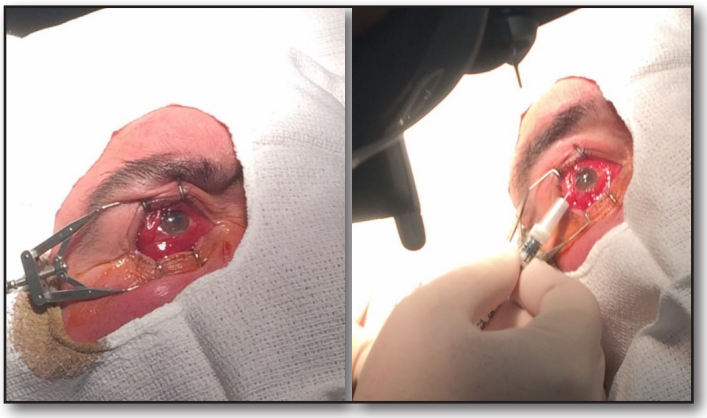
Corneas: Examined with fluorescein – no ulcers/uptake/abrasions

Pupils: Normal pupil shape, pupils right 8 mm (after dilation) left 4 mm

Anterior Chamber: Right hypopyon with cell and flare

Extraocular Movements: Intact

Posterior Segments/fundoscopic exam: Right unable to visualize due to significant haziness from the anterior chamber, left was normal



**Discussion:**

Ophthalmology was consulted and evaluated the patient in the ED. The ophthalmologist consult stated, "The patient had no recollection of direct globe trauma; however, microperforations of the globe are suspected in this case due to the CT evidence of periorbital foreign bodies and clinical course. The endophthalmitis diagnosis fits the clinical course of severe, progressive, and worsening symptoms with application of steroids." The final diagnosis per the ophthalmologist was "presumed intraocular microperforations of the globe that led to late onset posttraumatic endophthalmitis."

Treatment in the ED included: TDAP, Avelox 400 mg PO, Norco, and preservative free intravitreous antibiotics - Vancomycin 10 mg (1 mg/0.1 cc concentrate) and Ceftazadine 22.5 mg (2.25 mg/0.1 cc concentrate). The patient was then discharged home with Avelox PO (moxifloxacin) and Norco (hydrocodone/acetaminophen). He also continued his ofloxacin, atropine, and durezol drops. He was scheduled for next day follow up in the ophthalmology office.

Overall, this patient had a good outcome. By his 2 week follow up appointment with the ophthalmologist his vision was 20/40 on the right and 20/25 on the left. His vitreous fluid culture results showed: Isolate 1 – rare *Bacillus* species not *anthracis* and isolate 2 – rare normal skin flora.

Although endophthalmitis is a relatively rare infection of the eye, it has serious implications with potential for permanent vision loss. Endophthalmitis essentially is inflammation of the intraocular structures including aqueous/vitreous humor usually caused by infection, although noninfectious (sterile) causes may also occur. (1) Two types exist: endogenous (from hematologic spread from distant sources) and exogenous (direct inoculation from surgery, foreign body, or trauma). The majority of cases are from intraocular surgery – post cataract surgery has a 0.1-0.3% risk. Other risks include intravitreous injections which carry a 0.029% risk, penetrating ocular trauma which has a 4-13% risk, and retained intraocular FB which has a 7-31% risk. (1)

Many organisms have been implicated in causing endophthalmitis. For endogenous infections, the organism would depend on the source of the infection. The most common cause of exogenous endophthalmitis is *Staph aureus* followed by *Strep* species. Other causes include *Bacillus cereus* (IVDA, intravitreal injections, and the most common cause in traumatic cases), *E. coli* (most common Gram negative), and *Candida albicans* (most common fungal source). (1)

**References:**

1. Egan, Daniel MD. Endophthalmitis. Emedicine. Updated April 6, 2015. Available from: http://emedicine.medscape.com/article/799431-overview

# EMRAM – CALL FOR ABSTRACTS

## RESIDENT RESEARCH DAY
## APRIL 18, 2017
## CMU Saginaw Education Building, Saginaw, MI

EMRAM is accepting abstracts for presentation at the EMRAM Research Day. This is an opportunity for residents to present their work to others across the state and to learn about what others are doing. This would be especially helpful for those who are presenting nationally to have a trial run and it will also give senior residents an opportunity to present their scholarly projects. To expand the relevance of this forum to more senior residents and highlight other scholarly work we will be expanding the program this year to solicit abstracts for scholarly activities that are not purely research.

Residents or fellows are encouraged to submit abstracts of their scholarly work. The format is as follows: those that are presenting at the national meeting would present in the same format whether it be an oral presentation or poster. This will also give them an opportunity to improve upon their presentation in front of a group other than their own program. Each oral presentation will be no longer than 8 minutes in length with 4 minutes for questions and discussion. Posters will be presented in a small group moderated poster session. Non research scholarly abstracts (e.g. case reports, quality improvement initiatives) will be considered for a limited number of poster presentation spots as well.

***Abstracts must be received no later than March 7, 2017.*** Abstracts can be e-mailed to the Chapter office at mcep@mcep.org. Follow-up communication will be forwarded to all who submit abstracts in late March.

All abstracts must be limited to 300 words. The format must be structured and include the following: Objectives, Methods, Results, and Conclusions. Each abstract must be accompanied by a cover letter detailing the full names and titles of authors and should indicate the presenting author. The submitted abstract should be blinded with a cover sheet identifying study title, authors, and sponsoring institution. The cover sheet should also identify whether the author will accept an opportunity to present a poster presentation, or an oral presentation or either. EMRAM offers a special award for the papers determined best by the judges.

Please contact the MCEP Chapter office should you have any questions. §

***Send abstracts to:***
**EMRAM, 6647 West St. Joseph Highway, Lansing, MI 48917 or mcep@mcep.org.**

# CALLING ALL INTERESTED RESIDENTS.....

## IT IS TIME FOR THE ANNUAL EMRAM OFFICER ELECTIONS

The offices of President, Vice President, Secretary and Treasurer will be filled. Positions are intended for residents that have demonstrated a commitment to emergency medicine; and through this commitment are interested in furthering the programs, activities, and success of the Michigan Emergency Medicine Residents' Association.

Elections will be held during the EMRAM Research Day at the CMU Education Building in Saginaw on **Tuesday, April 18, 2017. Candidates interested in running for office need to submit their intent to run and the office they are interested in by noon on Friday, April 7th. Candidates should submit a personal statement and photo to be distributed prior to elections. Candidates running from the floor, without prior thought to the responsibilities and duties of office, are strongly discouraged.**

If you are interested in running for an office, please contact the Chapter office by phone, (517) 327-5700 or by e-mail, mcep@mcep.org. §


## MCEP Calendar of Events

**March 1, 2017**
Board of Directors
Chapter Office
Lansing, Michigan

**March 9, 2017**
Critical Care Practice in the ED
Somerset Inn
Troy, Michigan

**March 12-15, 2017**
ACEP Leadership Conference
Washington, DC

**April 18, 2017**
SIMWARS/Annual Meeting/
Research Forum
CMU Education Building
Saginaw, MI

**April 27-28, 2017**
APLS
Spectrum Health
Grand Rapids, Michigan

**May 3, 2017**
Board of Directors
Chapter Office
Lansing, Michigan

**May 6, 2017**
Mock Oral Boards
Sinai-Grace Hospital
Detroit, Michigan

**May 12, 2017**
SaveMIHeart Conference
Livingston Co. EMS Complex
Howell, Michigan

**July 30 – August 2, 2017**
Michigan EM Assembly
Grand Hotel
Mackinac Island, Michigan

**July 31, 2017**
Board of Directors
Grand Hotel
Mackinac Island, Michigan

**August 15, 2017**
Residents' Assembly
The Johnson Center
Howell, Michigan

**September 6, 2017**
Board of Directors
Chapter Office
Lansing, Michigan

**September 14-15, 2017**
Observation Medicine
Double Tree Downtown
Nashville, Tennessee

**September 18-19, 2017**
EM Ultrasound Course
Chapter Office
Lansing, Michigan

**October 10, 2017**
MCEP Councillor &
Board of Directors Meetings
Chapter Office
Lansing, Michigan

**October 28-29, 2017**
ACEP Council Meeting
Washington, DC

**October 30 – November 2, 2017**
ACEP Scientific Assembly
Washington, DC

**November 13, 2017**
LLSA Review Course
Chapter Office
Lansing, MI

**November 16, 2017**
Straight Talk
The Johnson Center
Howell, Michigan

**December 6, 2017**
Board of Directors
Chapter Office
Lansing, Michigan

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

**Executive Committee**

Larisa Traill, MD, FACEP — *President*
president@mcep.org

Jacob Manteuffel, MD, FACEP — *President-Elect*

Rami Khoury, MD, FACEP — *Treasurer*

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