MCEP
ADVANCING EMERGENCY CARE

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Submissions to the September Newsletter should be received by the Chapter office no later than September 4, 2016.

FROM THE PRESIDENT

Larisa Traill, MD, FACEP

It is with great pleasure that I write my first column as your illustrious president. I welcome this literary venue and look forward to working with MCEP's *News & Views'* talented editorial staff. In this first report tradition calls for a brief summary of the College's recent scientific assembly.

MCEP's annual Emergency Medicine Assembly on Mackinac Island was an enormous success and a perfect blend of emergency medicine education, college activities, family time, and fun. A special thank you to all the emergency physicians who worked during the conference to keep emergency departments running so that others, such as myself, could attend. MCEP was honored to have AMA President, Dr. Steve Stack in attendance, in addition to: ACEP President-Elect, Dr. Becky Parker, ACEP Vice-President, Dr. John Rogers, and ACEP Board of Directors members, Drs. Hans House and Paul Kivela. Also present were Dr. James Williams (TX), Dr. Kevin Klauer (OH), and Dr. Matthew Watson (GA), candidates running this year for ACEP's Board of Directors. As such, each of these physicians was afforded the opportunity to address the membership at the annual meeting on Monday afternoon. Chapter elections were also held at this meeting for the 2016-2017 MCEP Board of Directors; congratulations to Drs. Brent Felton and Diana Nordlund who were elected to their first term on the board and a warm welcome back extended to Drs. Rami Khoury and Mike Nauss who were re-elected to their second term. At the same time, Drs. Carol Clark, Kevin Monfette, and Luke Saski, having completed their respective terms on the board were commended for their years of service and their immeasurable contributions to the advancement of the College. At the board of directors meeting that followed, Drs. Warren Lanphear and Rami Khoury were welcomed to the College's Executive Committee as Secretary and Treasurer respectively.

Several other conference highlights included the Opening Reception (complete with a registrant photo op on the front porch of the Grand Hotel), the Presidents' Banquet, and the always back-by-popular-demand, Minute-To-Win-It MEDPAC (Michigan Emergency Doctor's Political Action Committee) Fundraiser, which proved, as usual, as amusing for the observers as it was for the participants. This year I believe my purple clad team would have won had Dr. Luke Saski not flagrantly thrown the last challenge. Having never actually been on a medaling team, I intend to start recruiting talent for next year early. I should also admit that my husband and Dr. Saski made every effort in all good sportsmanship behavior to covertly amend the scoreboard in our favor; kudos is due to Dr. Malinowski for graciously tolerating their shenanigans yet again. Fortunately, unlike years past, no one was lobbed in the fountain...at least to my knowledge.

The annual Gregory L. Henry lecture took place the last evening of the conference after a short cocktail reception and following the ever popular yet curiously named Deathbuster's Golf Outing. This year's Henry talk was given by the most superb of speakers, Dr. Amal Mattu. Replete not only with personal anecdotes but also entertaining lessons from characters such as Winnie-the-Pooh, a more inspiring leadership talk I cannot imagine. The ensuing President's Banquet was as entertaining as ever due to Dr. Whitehead's quick wit and well-honed skills as our MC. The banquet honored past Chapter leaders as well as the Chapter's 2016 award recipients. A complete list of all of 2016 award recipients is available on the MCEP website, www.mcep.org.

We hope you will join us next July when the College returns again to Mackinac Island to celebrate the 44th Michigan Emergency Medicine Assembly with another fabulous four days of a wide variety of CME opportunities and fun-filled family activities amid the old-world charm and unparalleled romantic Victorian elegance of the world-renowned Grand Hotel. I can think of nothing more alluring than a chance to reconnect with family and friends on the world's largest porch...preferably with a cool drink on a slow stroll in a big hat. And for those of you, who may have family members particularly skilled in activities involving items such as Ping-Pong balls and toilet paper, please see me about joining a winning MEDPAC fundraising team...clearly my team will accept enthusiasm in lieu of actual skill.

As we now look ahead to 2016-2017, the upcoming ACEP Council Meeting, and ACEP Scientific Assembly in Las Vegas, I look forward not only to serving as the College's President, but also continuing to Chair the College's Education Committee, the Committee whose members put so much time and effort into putting on such memorable events. Thank you for this opportunity; I aspire to meet the high standards set by the many distinguished leaders before me. §

MACRA — MIPS AND APMS — PATH TO PROSPERITY OR ROAD TO RUIN?

Lynn Nutting, Revenue Cycle Coding Director, University of Michigan Health

James Blakeman, Senior Vice President, EGO, Inc., an emergency physician billing and coding company

Is this the beginning of the end? Some believe that fee-for-service medicine is not likely to survive this latest round of complex payment schemes and that independent emergency physician groups will soon be on the endangered list. The changes appear to some to be so daunting as to overwhelm the average emergency physician group who is already looking to meet its commitments to its patients, hospital and providers.

The Medicare and CHIP Reauthorization Act of 2015 (MACRA) was a landmark piece of legislation that put into law various cost-containment schemes that have been swirling around CMS for years. It ended the dreaded SGR policy of pushing down the road each year draconian cost reductions, replacing it with the "volume-to-value" mantra chanted throughout the new legislation. Most notably, it added to the reimbursement lexicon of acronyms, the two that will affect emergency physician reimbursement the most in coming years, MIPS and APMs.

Even with a delay of implementation past the expected 2017 start, changes are coming so let's first look at what the changes mean.

As it stands today, fee schedule updates in 2016-2019 will increase at a base rate of 0.5% overall in each year, with some other small adjustments made each year based on RVU expansion and contraction. No updates are planned after 2019 as value based payment methodologies will be in effect.

The PQRS reporting system will likely be phased out this year and will affect payments up or down, in 2018 or the first year of MACRA implementation, by as much as 6%, as it will in 2017. In the first and second years, 2017 and 2018, new MIPS-defined measures that look and feel just like PQRS measures will be reported and begin affecting payments in 2018 and 2019 at the same +/- 6% rate. For the near future, claims-based reporting still exists so not much needs to change immediately to participate effectively in PQRS in 2017 and the MIPS incentive program after that.

However, unless further delays are planned by CMS, bigger changes take place January 1, 2019.

The Merit Based Incentive Program (MIPS) and the Alternative Payment Models (APM) program are two paths to the same destination – cost reduction with a nod toward quality improvement. The paths cross occasionally but are essentially different ways to be rewarded or punished for changes in certain practice performance measures.

When emergency physicians read "merit-based," the conditioned response is – they are taking away payments. That is both true and false in many regards. There is a component where, without impossible hurdles, emergency practices can win some additional reimbursement but it is largely a zero-sum game, some will win what others will lose.

Under MIPS providers will be scored up to 100 points on quality, resource

(Continued on Page 4)

Dates Related to MACRA:

- On April 27, CMS released the proposed rule related to Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- On June 27, the public comment period ended
- On January 1, 2017 the final rule will be published by CMS and MACRA reporting will go live
- It is suspected that MACRA reporting scheduled for January 1st 2017 may be delayed until July 1st, 2017

Reimbursement Changes Related to MACRA:

- 2016-2019 Fee Schedule increase of 0.5% overall yearly
- 2019 payment +/- 4% based on 2017 MIPS Performance Period
- 2020 payment +/- 5% based on 2018 MIPS Performance Period
- 2021 payment +/- 7% based on 2019 MIPS Performance Period
- 2022 payment +/- 9% based on 2020 MIPS Performance Period

MACRA Participation:

- Beginning in 2017 enroll in either:
  - Merit-based Incentive Payment System (MIPS) or
  - Advanced Alternative Payment Models (APMs)
    - Those not enrolled in an APM must enroll in MIPS with a few exclusion (see link below for providers who do not have to enroll in MIPS or APM)
    - Most providers will enroll in MIPS as there are limited Advanced APMs that providers qualify for

Please find the following link for a detailed account of MACRA:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

REIMBURSEMENT CORNER

(Contined from Page 3)

use, clinical practice improvement, and EHR use, with payments adjusted according to your score compared to everyone else's scores.

MACRA places most Medicare providers into two major value-based programs, which together are termed the Quality Payment Program (QPP). Groups qualifying in one do not need to participate in the other, but there will be advantages for successful participation in both.

The Merit-Based Incentive Payment System (MIPS) rates clinicians each year on a 100-point performance scale, where providers compete with each other over positive or negative adjustments to their payments with the ultimate goal of budget neutrality. The Alternative Payment Models (APMs) include other measurement schemes that set requirements for the use of certified EHR technology, quality measurement, and financial risk. A practice that participates in a qualified APM is exempt from MIPS, while some participants in Advanced APMS have the option to participate in MIPS, as well.

APM involvement can be very good for emergency physician groups when entered into advisedly. It does not require becoming a hospital employee, or even an ACO employee. Group practices can still be an essential player in the hospital's ACO/APM. Venture capital is pouring millions into buying physician groups, just as they did in the 1990s, because they understand this. Independent practice is not going away, it's just changing and will need administrative support to engage profitably with the new entities and players in the ACO/APM marketplace.

What can individual physicians and physician groups do to find the path to prosperity under MACRA?

Start with where you are – like politics, all reimbursement is essentially local. If you're billing independently, be certain your billing operations are helping you meet the MIPS scoring measures so that you avoid the penalties. CMS estimates that 54.1% of all providers will be winners and 45.5% will be losers, only 0.4% will break even. With a small amount of planning and performance improvement, your practice can hold its own.

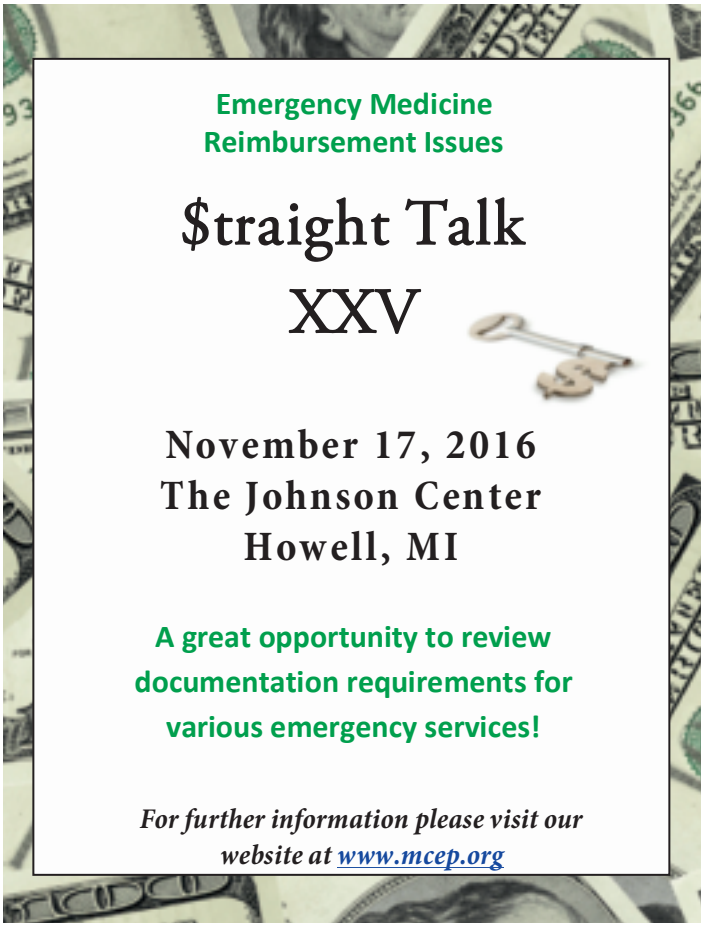
If you have MIPS reporting done successfully, you will not need to participate in an APM. But, if a good one is available, you might want to join up. Emergency physician groups can profit from the overall performance of an APM when they share in the 5% bonus available to all participants in a qualified APM.

It is a fact that the definitions of successful "performance" under these programs are complicated. Very complicated. PQRS rules were not abundantly clear; these are much more difficult to master. So, the programs play into suspicions that the system is intended to work against a physician group. That's not the clear intent. On first read, it might seem that way but be careful not to over-react.

Whenever CMS changes the rules of the game, the new rules are strange and complicated, until we learn them. When managed care hit emergency medicine in the early 90s, groups sold out to hospitals or larger groups who were forming PSOs (Physician Service Organizations) to contract with the new health plans and despair set in. The practice of emergency medicine appeared destined to be lost as patients would be kept out of EDs by managed care plans and capitation, the new pay scheme, shut out emergency medicine. When the 1995 Documentation Guidelines for Evaluation and Management Services were put in place by Medicare in the late 90's the reaction from the provider community was mixed with outrage, suspicion and reasonable fear that the system was too complicated to be mastered. It was all considered to be just another way for Medicare to take away money.

These changes did affect the practice of emergency medicine significantly, and not all for the better, but we learned how to accommodate and even to thrive as the true value of emergency physicians became clearer – we were really good at keeping patients out of the hospital, doing great workups far beyond what the primary care providers had the resources to do and we were flexible enough to accommodate documentation hoop-jumping. In the 20+ years since the 1995 DGs went into place, emergency medicine's reporting of 99285 services has increased from 25% of all ED-billed Medicare patients to 57% of all ED-billed patients. So, we've learned and adapted, as emergency physicians are very capable of doing.

Remember, fee-for-service reimbursement as we have known it is not going away. Not now, possibly not ever. MACRA simply lays a cost-containment cap onto it, just like SGR used to do and like managed care did before that. The new payment mechanisms are certainly more complicated (capitation formulas from the 90s were not very simple) but they do not mean the end of productivity-based compensation or the opportunity to do well by doing good. §



PHYSICIANS/POSITIONS AVAILABLE

BAY CITY, MICHIGAN: MCLAREN BAY REGION, EMERGENCY MEDICINE OPPORTUNITY. Explore an excellent opportunity for a BC/BE Emergency Physician or board certified FP, IM, GS with at least 5 years contiguous Emergency Department experience, to join our group in either a full or part-time capacity at a growing, profitable hospital in Bay City. Since opening a new ED in 2007, patient volume growth has been steady with an expected 45,000+ patient visits this year. McLaren Bay Region has a supportive administration team and progressive medical staff that provides coverage for all of the major specialties. Our group offers a stable contract and sign on bonus with productivity compensation package opportunity in excess of $200/hour. Current staffing reflects 40 hours physician coverage with mid-level assistance in main ED and Fast Track. Bay City and surrounding communities offer affordable housing and a short commute to major cities and Northern Michigan. If you are interested in this opportunity, please send CV to Kenneth Parsons, M.D., M.P.H., FACEP, at kpmdmph@comcast.net or call 989-894-3145 for more information. [ufn]

BEAUMONT HEALTH: Beaumont Health Department of Emergency Medicine is seeking candidates for full time employment for the Beaumont Troy Campus. The successful applicant will be board certified/eligible in emergency medicine. Applicants must have M.D. or equivalent. Accredited by the Joint Commission as a Stroke Center of Excellence as well as being an accredited Chest Pain Center and has level 2 trauma designation with a volume approaching 100,000 visits a year. Physician is expected to work 14 shifts/month. Salary and benefits package are competitive. If interested in this opportunity, please forward CV to: Roberta Simone, MSA, BSMT, at Roberta.Simone@Beaumont.org [3-1]

CASS CITY, MI: Seeking a BC/BE Emergency Medicine Physician for a full-time position in our 5,500 visits/year, low volume Emergency Department. This is an opportunity to practice Emergency Medicine in a spacious new Emergency Department with supportive administration and outstanding ancillary staff. We work 24 hour shifts and have an on-call suite for resting at night. The hospital offers competitive compensation which includes comprehensive benefits, CME and PTO. If interested please send CV to Scott Greib, MD, FACEP at sgreib@hillsanddales.org or call 989-912-6296 for more information. [ufn]

KALAMAZOO, MI: Growing yet established democratic, group offering competitive benefit and preeminent shareholder package and sign-on bonus. Self-regulated schedule, midlevel coverage, scribe assistance, specialty back-up coverage, teaching opportunities. Looking for Board Certified/Board Eligible Emergency Medicine Physicians/Residents. Full-time, permanent for various level hospitals (from rural to level 1 trauma). Cultural community with easy 2 hour access to either Chicago or Detroit. **Email CV to corporate@swmes.com Attention President, Jim De Moss, DO, FACEP or asmith@swmes.com** *Group info: www.swmes.com* [6-2]

MID/SOUTHEAST MICHIGAN: Opportunities for experienced, BC/BE Emergency Medicine Physicians. We are looking for candidates to join our expanding, well-staffed team environment that offers a complete benefit package. Emergency Physician coverage, including leadership positions, located in Bad Axe, Clarkston, Garden City, Lansing, Lapeer, Pontiac, Saginaw, Standish, and Tawas. For all inquiries, please contact Denise DeLisle at 248-338-5836 or email CV to denise.delisle@degarapllc.com [6-1]

PETOSKEY, MI: Northern Michigan Emergency Physicians, PC, a well-established democratic group providing the Emergency Services in Petoskey for 17+ years, is seeking a Full-Time BC/BE Emergency Physician. Stable contract with competitive compensation and benefit package. Excellent reputation and relationship with Administration and Medical Staff. Regional Referral Hospital with comprehensive subspecialty coverage and annual ED volume of 25,000 visits. 4 Physician shifts and 1 APC shift/day. For details contact Kal A. Attie, MD, FACEP at 231-838-2655 / kalattie@mac.com. [3-1]

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 [5-1]

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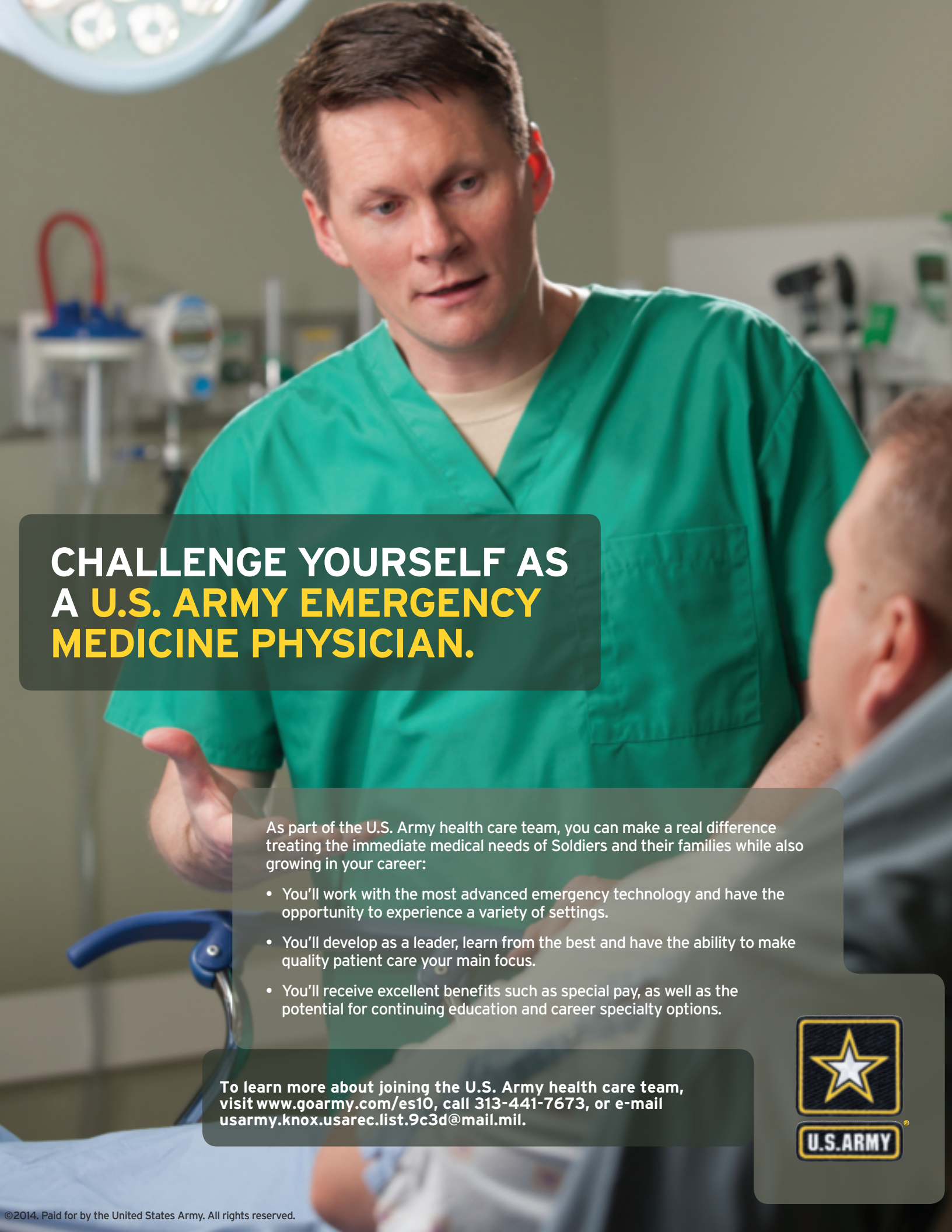

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As part of the U.S. Army health care team, you can make a real difference treating the immediate medical needs of Soldiers and their families while also growing in your career:

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U.S.ARMY

43RD MICHIGAN EM ASSEMBLY

Gregory Gafni-Pappas, DO

The 43rd Michigan College of Emergency Physicians was held at the beautiful Grand Hotel on Mackinac Island on July 31-August 3, 2016. Over one hundred forty physicians and other emergency medicine specialists and their families participated in three days of excellent educational programs and family fun.

The conference started Sunday afternoon with a Heart Failure Management Symposium. The MCEP traditional Opening Reception took place on the Front Pouch with a breathtaking view of the Mackinaw Straights. Adults enjoyed cocktails and hors d' oeuvres, while children took pleasure in their very own reception with crafts and treats.

Monday, August 1st kicked off the educational segment of the Assembly with our exceptional speaker lineup. The Annual Membership Meeting followed with elections that were held for the 2016-2017 MCEP Board of Directors. Congratulations to the newly-elected Board members: Brent Felton, DO, FACEP, Rami Khoury, MD, FACEP (incumbent), Michael Nauss, MD, FACEP (incumbent) and Diana Nordlund, DO, JD, FACEP. Congratulations are also in order for Sara Jacob, MD who was appointed on the Board as the new candidate representative. Dr. Ziadeh gave his outgoing Presidential address and was presented with his presidential jacket along with handing over the gavel to MCEP's new President, Larisa Traill, MD, FACEP.

Immediately following the Annual Meeting was the first 2016-2017 Board of Director's meeting. The elected officers for the 2016-2017 Executive Committee positions were:

President: Larisa Traill, MD, FACEP
President-Elect: Jacob Manteuffel, MD, FACEP
Treasurer: Rami Khoury, MD, FACEP
Secretary: Warren Lanphear, MD, FACEP

The annual "Minute to Win It" fundraiser for MEDPAC was once again a success. It was a fun activity for physicians, families and exhibitors to show off their talent trying to complete a particular task in 60 seconds or less. The winning team this year was Dr. Warren Lanphear and Lauren Lanphear, Dr. Millie Willy and Mr. John Herek, and Dr. Rebecca Parker & Family. Congratulations to all!

The Gregory L. Henry, MD Lecture featured presenter Dr. Amal Mattu speaking on the topic of "Everyday Leadership – Secrets of Great Minds through the Ages." The Presidents' Banquet followed where MCEP was honored by the presence of fifteen (15) Past MCEP Presidents. Annual awards were presented to the following:

Dennis Whitehead, MD, FACEP – John A. Rupke, MD, Lifetime Achievement Award
Robert Orr, MD, FACEP – Emergency Physician of the Year Award
Robert Domeier, MD, FACEP – Legacy Award
Michael Baker, MD, FACEP – Ronald L. Krome, MD, Meritorious Service Award
Michelle McLean, MD, FACEP – EMRAM Excellence in Teaching Award
Jacob Manteuffel, MD, FACEP – Significant Contribution Award

Thank you to the following vendors who without their support we would not be able to provide this top-notch conference to our members:

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Thank you also to the Following Exhibitors:

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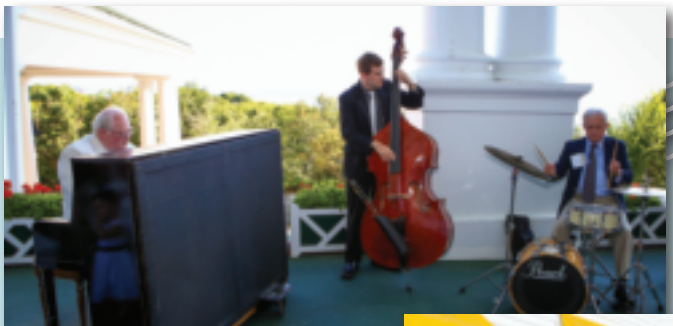
Pfizer Inc.
Thermo Fisher Scientific
Wakefield and Associates
U.S. Army Healthcare
Zotec Partners

The last weekend in July next year, July 30-August 2, 2017, the College will return to the Grand Hotel on Mackinac Island for the 44th Annual Michigan Emergency Medicine Assembly. This event will once again continue to provide up-to-date information on issues, topics, and techniques that will help emergency physicians strengthen their practice along with fun activities for the whole family. §

2016 Scientific Assembly

Opening Reception



Annual Meeting

President, Larisa Traill, MD, FACEP presents her Inaugural Address.

Dr. Larisa Traill receives the traditional presidential gavel from Past President, Dr. James Ziadeh.

Larisa Traill, MD, FACEP presents outgoing president, Dr. James Ziadeh, with the Gavel Award for his service to the Chapter.

Diane Kay Bollman presents Dr. James Ziadeh with his president's jacket.

Minute to Win It Event

President's Banquet

Dr. Michelle McLean (left) receives this year's EMRAM Excellence in Teaching Award from Dr. Kathleen Cowling.

Dr. Michael Baker receives the Ronald L. Krome, MD Meritorious Service Award from Dr. Kathleen Cowling.

Dr. Robert Domeier receives the Legacy Award from Dr. Larisa Traill.

Dr. Dennis Whitehead receives this year's prestigious John A. Rupke, MD Lifetime Achievement Award from Dr. Joseph Bustamante.

Dr. Jacob Manteuffel receives the Significant Contribution Award from Dr. Michael Baker.

Dr. Robert Orr receives the Emergency Physicians of the Year Award from Dr. David Komasara.

MCEP was honored by the presence of fifteen Past MCEP Presidents.

By: Christopher Sponaugle, MD and Anne Messman, MD, FACEP of the Emergency Medicine Residency at Wayne State University/Detroit Medical Center/Sinai-Grace Hospital, Detroit, MI.

"THE RECURRENT ATRAUMATIC SPLENIC RUPTURE"

Introduction

Atraumatic or spontaneous splenic rupture (ASR) is an uncommon occurrence, generally related to a neoplastic or infectious process. Despite its rarity ASR can present as a life threatening condition with high morbidity and mortality. Recent review revealed a splenectomy rate of 84% with an overall mortality rate of 12% regardless of treatment modality. We present a case of atraumatic splenic rupture.

Case Report

A 49-year-old female with history of cerebral aneurysm, hypertension and sickle cell trait presented to the ED with acute onset left sided chest and abdominal pain. The pain started suddenly with no preceding trauma, and the patient denied recent illness. On initial examination the patient's vital signs were stable without fever, tachycardia or hypotension. Physical examination revealed left lower chest wall and severe left upper quadrant tenderness and guarding without abdominal distention. Laboratory studies revealed normal hemoglobin, hematocrit and electrolytes. CT of the abdomen showed a grade III splenic injury involving the superior aspect of the spleen with peri-splenic blood (fig 1). There was also free fluid in the dependent portion of the pelvis. The patient was subsequently admitted to the general surgery service for further management. Extensive laboratory workup was initiated to look for possible causes of splenic rupture. Tests for infectious mononucleosis were negative, liver function tests and amylase and lipase were within normal limits suggesting no hepatic or pancreatic pathology. Serial hemoglobin and hematocrit tests remained stable and repeat CT scan showed a stable splenic laceration with decreased in the amount of intra-peritoneal free fluid. She was subsequently discharged after several days of observation with surgery clinic followup.

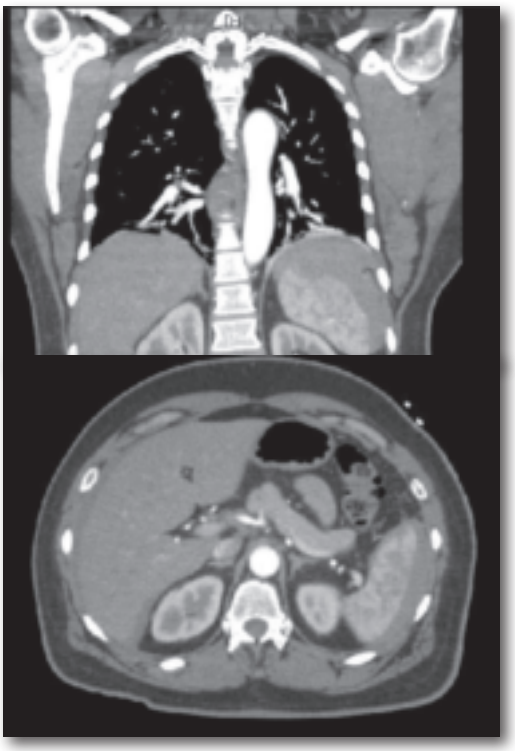


Figure 1: Coronal (top) and Transverse (bottom) views demonstrating splenic hemorrhage

Several months later the patient presented to a separate facility with similar complaints, complaining of severe pain that had started suddenly three hours prior to presentation. Once again the patient denied trauma of any kind. At that time a similar laboratory and radiographic workup was completed. CT scanning demonstrated an early splenic rupture and demonstrated a splenic hemangioma. The patient was admitted to the medicine service with a general surgery consultation. Consideration was given to splenectomy during that admission, however repeat CT scans did not show evidence of bleeding, the hemoglobin remained stable and the patient's pain came under control. As such she was once again discharged with outpatient follow up.

Discussion

Atraumatic splenic rupture is rare, recurrent atraumatic splenic rupture is far rarer. This may be due in part to the high number of patients undergoing splenectomy following the original diagnosis. These patient's presentations vary greatly, but nearly always include pain, and sometimes present as an acute, rigid abdomen.

More than half of the cases of spontaneous splenic ruptures are attributed to neoplasm or infection. The literature classifies the causes into seven categories: neoplastic, infectious, hematologic, inflammatory, iatrogenic, primary splenic disorder, idiopathic. The wide variety of etiologies are displayed in table 1.

Diagnostic methods are similar to those used in traumatic splenic rupture and include ultrasonography and computed tomography (CT). In a recent review of 845 cases of ASR 42 percent of cases were diagnosed by direct visualization on laparotomy, although nearly all of those had previously demonstrated free intra-peritoneal fluid on CT or Ultrasound.

The Orloff and Peskin criteria classify a splenic rupture as "atraumatic" if it meets these four stipulations:

1. Thorough history reveals no antecedent trauma
2. No evidence of disease in organs that are known to affect the spleen adversely
3. No peri-splenic adhesions or scarring consistent with trauma or past rupture
4. Other than findings of hemorrhage and rupture the spleen should appear normal on gross and histological examination

Management of spontaneous splenic rupture depends on the degree of splenic injury and hemodynamic status. All patients require admission for observation, repeat hemoglobin and hematocrit and serial abdominal exams. Severe cases will require blood transfusion, ICU admission as well as invasive procedures including splenic artery embolization, and possible splenectomy. 20-40% of patients will require surgical intervention. Consideration should be given to immunization against encapsulated

organisms in these patients as with any splenectomy patient.

The etiology of the recurrent splenic rupture in our patient remains somewhat unclear. While she meets most of the criteria for spontaneous rupture, no tissue was available as the patient never underwent splenectomy. Given that a hemangioma was seen on her CT scan during her second admission one would wonder whether she falls into the primary splenic disorder category, or if that hemangioma was a product of the original rupture. She did undergo testing for mononucleosis, a common cause of splenic rupture as well as pancreatitis and other intra-abdominal pathologies which yielded negative results. While she did not undergo a comprehensive neoplastic workup, she did not have other historical or laboratory findings to suggest a leukemia or lymphoma. It may be that this patient falls into the idiopathic category, and certainly warrants further workup.

While rare, spontaneous or atraumatic splenic rupture should be considered in a patient with severe left upper quadrant pain, with or without an acute abdomen. If found, the emergency management of this patient should focus on hemodynamic stabilization, urgent surgical consultation, and pain control.

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Neoplastic	Infectious	Hematologic	Inflammatory	Iatrogenic	Primary Splenic Disorder
Leukemia	**Viral**	Hemophilia	Pancreatitis	Heparin/Warfarin	Splenic neoplasm
Lymphoma	EBV	Factor XIII deficiency	Amyloidosis	Dialysis	Congenital malposition
Polycythemia vera	CMV	Protein S deficiency	Lupus	Lithotripsy	Portal hypertension
Multiple myeloma	HIV	Idiopathic thrombocytopenia purpura	Rheumatoid Arthritis	Thrombolytics	Splenic infarction
	Hepatitis A/B/C		Polyarteritis Nodosa		Splenic vein thrombosis
	Rubella				Splenic cyst
	Varicella				Splenic angiomatosis
	Bacterial				
	Legionella				
	Bartonellosis				
	Infectious Endocarditis				

MCEP Calendar of Events

September 7, 2016
Board of Directors
Chapter Office
Lansing, Michigan

September 12-13, 2016
EM Ultrasound Course
Chapter Office
Lansing, Michigan

September 15-16, 2016
Observation Medicine Course
DoubleTree Hilton Hotel
Charleston, South Carolina

September 27, 2016
MCEP Councillor &
Board of Directors Meetings
Chapter Office
Lansing, Michigan

October 3, 2016
MCA Conference
Grand Traverse Resort
Traverse City, Michigan

October 4, 2016
Michigan Trauma Conference
Grand Traverse Resort
Traverse City, Michigan

October 14-15, 2016
ACEP Council Meeting
Las Vegas, Nevada

October 16-19, 2016
ACEP Scientific Assembly
Las Vegas, Nevada

November 14, 2016
LLSA Review Course
Chapter Office
Lansing, Michigan

November 17, 2016
$traight Talk
The Johnson Center
Howell, Michigan

December 7, 2016
Board of Directors
Chapter Office
Lansing, Michigan

December 9, 2016
Expert Witness
Tempe Mission Palms
Tempe, Arizona

January 7-8, 2017
EMRAM In-Service
The Johnson Center
Howell, Michigan

January 26-29, 2017
Winter Symposium
Mountain Grand Lodge
Boyne Falls, Michigan

January 28, 2017
Board of Directors
Mountain Grand Lodge
Boyne Falls, Michigan

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

May 3, 2017
Board of Directors
Chapter Office
Lansing, 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

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