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Submissions to the May/June 2019 Newsletter should be received by the Chapter office no later than May 20, 2019.
FROM THE PRESIDENT

What does it mean to advocate for our specialty and our patients? We all have individual ideas and views. Collectively as a college, we aspire to a higher standard. With that standard should come an understanding of how to accomplish our mission. Over the last number of years, I have realized that as physicians, we do not often understand how to accomplish that mission. We are experts regarding the medicine within our own field. That does not necessarily make us experts in policy, ethics, or health insurance. I know this might turn people off but I dare say - we are politically naïve.

Let us take a step back and look at an issue in which I have been deeply involved, the opioid epidemic. I watched as we argued over whether or not to give opioids to the 5% when 95% were being negatively affected. Make no mistake, the media and legislature is catching on. We blamed the system and the situation, and ignored our own behavior. As a result, physicians, as a whole, lost credibility in Lansing. MCEP spent a good amount of time negotiating on this key issue, and the fact that we started advocating before others was our only saving grace.

We as an association have many hot topic issues that we individually and collectively should take stands on, whether in Lansing or Washington DC. There are no absolutes, and whether we like the process or not, everything is a negotiation. What are our top priorities to focus on from year to year? What risks should we take to achieve the policy goals that are important to us? I suggest that it is better to know what the end game is, what the strategic approach should be, and how we should invest political capital. Remember, if you can play it right by getting what you want without investing political capital and without showing your political cards, it will pay off more in the long run for the issues that require more political savvy.

PROPOSED BYLAWS AMENDMENTS

Every four years, the ACEP Bylaws Committee initiates a routine comprehensive review of a Chapter’s bylaws. Based on the Committee’s distribution cycle of Chapter reviews, the Michigan Chapter is due for review in this 2018-2019 Committee year. The Committee conducts a comprehensive review of a chapter’s bylaws with particular attention to the following areas: (a) compliance with the requirements of and possible conflicts with College Bylaws; (b) compliance with the form and content of the Guidelines and Model Chapter Bylaws (MCB); and (c) internal consistency and overall clarity.

Proposed amendments are as follows (see the attached version in track changes with the deletions noted in strikethrough text and additions noted in underlined text):

- Article III Section 3: Recommended addition of the phrases “and privileges” and “consistent with” per MCB language. Also, a delineation of Candidate member rights should be stated here.
- Article IV Section 3: This section should be amended as indicated to include the proposed new MCB language, which affords increased clarity.
- Article V Section 1 & Section 2: The phrase “communicated in writing” encompasses electronic communication and is now preferred over “mailed to”.
- Article VI Section 2: Candidate members also include medical students. Since the Chapter’s intention is to have an emergency medicine resident representative on the Board, improved clarity would be to state “one Candidate physician member”. Furthermore, EMRAM (not all of the Chapter candidate members) is the designated body that elects the Candidate member Board representative and therefore the language should parallel that of the last sentence of Section 8.
- Article VI Section 3: Delineation of allopathic and osteopathic is antiquated and unnecessary.
- Article VII Section 11: The phrase “of the Board” is unnecessary.
- Article IX Section 4: The Finance Committee as outlined does not exist.

§
OVER-TESTING AND OVER-TREATMENT — A MATTER OF CONCERN

In a world of patient complexity and overload, it is not surprising that physicians tend to over-test and over-treat millions of patients each year. Not only does this lead to a financial burden on our society, but patients often get unnecessary diagnostics or medications that could have been avoided.

Why is this practice so egregious in our country? I offer four specific thoughts as to why this might be the case.

1) Medicolegal ramifications

It’s easy to understand that physicians in the United States are scared. I can’t count how many times I’ve been asked if I’ve been sued yet. Since my answer currently is no, the next response to come usually sounds something like this, “Well, your time will come.” This is sad. To know that most physicians will have at least one lawsuit in their careers undermines the entire healthcare system. We know that medicine is imperfect. There is no way to get the diagnosis correct in every patient. But because of the fear of lawsuit, we practice defensive medicine, some more than others. This often entails excessive testing and treatment even when it might not be indicated (i.e. antibiotics in viral URI). There is no obvious solution to this problem, but we need to be mindful when we are choosing a test or treatment for defensive purposes. Education and good patient relationships can be better lawsuit prevention and often offers better patient care than over-testing and over-treatment.

2) Patient satisfaction

Whether conscious or not, many physicians feel that we must do something for every patient. Perhaps this is because there is a perception that a patient will be more satisfied with a visit if they are given a medication, or if a test is performed. I submit that doing nothing can be just as satisfying if we take the time to listen to our patients and educate them on their condition. In fact, this discussion with the patient IS what we are doing for our patients. They come in for an evaluation by a specialist, and we give them our expert opinion. Just because a patient has a viral URI and does not require a prescription doesn’t mean that they don’t need information regarding their diagnosis, an explanation of why they don’t need an antibiotic, and how to care for themselves at home. This often takes more time than writing a prescription but can give the patient a much better understanding of their condition, better care, and ultimately more satisfaction during their visit.

3) Lack of a diagnosis

Being unsure of a patient’s diagnosis is par for the course in emergency medicine. We’ve all had the rash that could be dermatitis or shingles, the sinusitis that is at the stage between viral and bacterial, or the periumbilical pain that seems too vague or early to be appendicitis. There are a number of times when we walk out of a room unsure of the best treatment plan. Yet, many times we decide to test or treat to “err on the side of caution.” Sometimes this is appropriate, but many times it could be avoided. Observation at home or a trial of OTC medication might be the better treatment plan and it’s ok for a patient to return if their symptoms progress or worsen. We don’t always have to get it right the first time, but we do have to educate our patients regarding our plan, when to return or see their primary doctor, and why we think it’s the best course of action to take.

4) Convenience

How often do we test or treat out of convenience? It’s certainly easier to write an antibiotic script than to educate a patient. It’s also easier to treat for a UTI when a patient has a significant number of squamous epithelial cells than to recheck a clean urine. It’s also easier to admit a non-ambulatory patient than to work on an outpatient plan or try to admit directly to a SNF. We are asked to move fast and see a multitude of patients. But is it always the best care for the patient? Taking the time to be patient-centric by recognizing the needs and appropriate treatment for individual patients is always better than a cookie cutter model of diagnosis, treatment, and disposition.

Conclusion

I believe in patient-centered care. Our system of care often does not support this through multiple stressors on physicians, namely to be quick and diagnose 100% correctly. The system says there is no room for error, but there will always be error. If we take our time with each patient to educate them on their condition and the possible options, we can work to eliminate the unnecessary wastes that over-testing and over-treatment place on society, prevent personal risk, and ultimately improve the entire healthcare system.

MCEP Calendar of Events

<table>
<thead>
<tr>
<th>Event Name</th>
<th>Dates</th>
<th>Location</th>
<th>Event Type</th>
</tr>
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<td>Board of Directors</td>
<td>May 1, 2019</td>
<td>Lansing, Michigan</td>
<td>Michigan EM Assembly</td>
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<td>Chapter Office</td>
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<td>Grand Hotel</td>
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<td>May 5-8, 2019</td>
<td>ACEP Leadership Conference</td>
<td>Washington, DC</td>
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<tr>
<td>May 11, 2019</td>
<td>Mock Oral Board Review Course</td>
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<td>May 30 – June 2, 2019</td>
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<td>Crystal Mountain Resort, Thompsonville, MI</td>
<td>Mackinac Island, Michigan</td>
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FROM THE EDITOR

Gregory Gafni-Pappas, DO, FACEP

OVERTESTING AND OVERTREATMENT — A MATTER OF CONCERN

News & Views
**VIOLENCE IN THE EMERGENCY DEPARTMENT**

MCEP continues to work with legislators in both chambers to put in place tougher penalties for individuals assaulting health care workers in the hospital setting. We are pleased to support legislation introduced by Senator Ken Horn, Senate Bill 80, and House Bills 4328 and 4329, introduced by Representative Hank Vaupel. The House Bills were referred to House Judiciary and we expect to have hearings on those bills later this spring. We will use the MCEP Leadership Development Program Lansing Day to lobby members of the committee on the issue. Watch for an Action Alert from MCEP when it’s time to contact your State Representative for action.

**AUTO NO FAULT**

Speaker Lee Chatfield and Senate Majority Leader Mike Shirkey kicked off the session with speeches about auto no fault being their number one agenda item. The Speaker created a committee specifically for auto no fault reform and the Senate introduced Senate Bill 1 as its first bill on no fault. The Senate committee has been conducting hearings on the issue for the past couple of months. We expect the Senate to act in late April or early May to pass a reform bill and send it to the House. Governor Gretchen Whitmer has been quiet on the subject in the press but several GOP leaders on the issue have commented that she needs to show the Legislature some willingness to sign a no-fault bill if they are going to adopt some of her budget proposals. We fully expect a no-fault bill to move through the Legislature this spring or early summer. Please watch for Calls to Action on this subject.

**FIRST 100 DAYS OF THE WHITMER ADMINISTRATION**

After an unprecedented Lame Duck session in 2018, the 100th Legislative session has kicked off and Governor Gretchen Whitmer was sworn into office. There are a few new leaders that MCEP works with on a regular basis that need to be introduced. Governor Whitmer has been a friend to MHSA and MCEP over the years in her many roles in and around state government. A huge supporter of Medicaid expansion and health care in general, we look forward to continuing to work with her. She appointed Robert Gordon as her Director of the Michigan Department of Health and Human Services. Director Gordon served in the Obama Administration in D.C. and knows education, budgets and healthcare from a variety of perspectives.

Director Gordon has spent the better part of three months putting Whitmer folks into leadership positions in DHHS. The Gordon DHHS has questioned the likelihood of a CMS waiver for Medicaid recipient work requirements passed in 2018. He has also had to spend significant time trying to fix a broken computer system that has drastically delayed payments and assistance for heating bills in a record setting cold first quarter of 2019. The legislature has also had significant angst toward the new Director’s decision to slow down construction of a mental health facility in Caro. Given all the early challenges, it would be easy to forget all of the proactive things the department has embarked upon, but Director Gordon has kept his focus on Governor Whitmer’s spending priorities and making continued progress in Flint. §
100% Membership Recognition Program

We proudly recognize these groups that have all eligible emergency physicians enrolled as members of the College.

Certified Emergency Medicine Specialists

Covenant HealthCare

Emergency Care Specialists, PC

Grand River Emergency Medical, PLC

Henry Ford Hospital Emergency Department

Medical Center Emergency Services/DMC

Midland Emergency Room Corporation, PC

Since 1998 the Michigan College of Emergency Physicians has been proud to recognize emergency medicine groups and emergency departments that have attained 100% membership in MCEP/ACEP.

The 100% Club Recognition Program is a great way to save money (national ACEP activation fees, etc.), save time (receive one master invoice), and be recognized for your commitment to professional development.
TWO MIDNIGHT RULE

The ‘Two Midnight Rule’ refers to the Medicare language associated with the reasonableness of a provider placing an inpatient admission order. A physician should order inpatient care if the provider has a reasonable expectation that a patient will require two midnights of a medically necessary hospital stay. Two midnights may include care provided while the patient is classed as an outpatient at the current hospital (i.e. ED, observation, post outpatient surgery) or is either an inpatient or outpatient prior to arrival when a patient is transferred from an outside hospital.

If inpatient admission is ordered and is reasonable, and a patient leaves early, inpatient days may be billed based on ‘unforeseen circumstances.’ Additional unforeseen circumstances include death or transfer, leaving against medical advice, hospice care is ordered in lieu of treatment or unexpected clinical improvement occurs. Additionally, if a patient receives two midnights of outpatient care, and discharge is planned on the third day, an inpatient admission may be ordered.

Note that inpatient stays due to social issues such as post discharge placement are not reasons to continue charging for inpatient days. Rather, the insurance or patient is billed for the remainder of the stay. However, if a physician certifies the need for skilled nursing care at a skilled nursing facility (SNF) and no SNF bed is available, then continued inpatient hospitalization is appropriate until a bed is obtained.

Once an order for inpatient care is placed, Utilization Review (UR) evaluates the patient’s medical history and comorbidities, the severity of signs and symptoms, the patient’s current medical needs, and the risk/probability of an adverse event occurring during the time period being considered for inpatient hospitalization. Typically, InterQual, an electronic UR tool, is used to facilitate inpatient decision making, although other software is available and may be employed. Should an admission order be overturned by UR, the admitting attending is notified and is given the opportunity to change the order to outpatient/observation or to uphold the inpatient request. If the attending does not agree with an outpatient status change, the case is referred to an internal UR committee and potentially may be transferred for external UR evaluation. If an attending ultimately agrees that a patient’s care does not warrant inpatient admission, then the attending acknowledges the status change in the patient’s record and the patient is notified of their outpatient financial liability by the hospital. Should the attending’s inpatient request for services be supported by UR, the case is considered an exception to the Two Midnight Rule and is billed as such. §

2019-2020 EMRAM OFFICERS

The offices of President, Vice President, Secretary and Treasurer have been filled for the 2019-2020 calendar year. We would like to congratulate the following:

- President - Ryan Powell, DO - Central Michigan University Residency Program
- Vice-President – David Kramp, MD - Central Michigan University Residency Program
- Treasurer – Andrew Ostosh, MD - Central Michigan University Residency Program
- Secretary – Craig Thomas, MD - Central Michigan University Residency Program
INTRODUCTION

Pott’s puffy tumor (PPT) is a rare condition characterized by frontal bone osteomyelitis with a subperiosteal abscess, often associated with trauma or frontal sinusitis.1 We present a case of a 10 year-old female whose condition was caused by both.

CASE

The patient is a 10 year-old female with no significant past medical history who presented to the emergency department with complaints of fever for 4 days. She had several pertinent preceding events. One week prior to presentation, she accidentally struck her head on a metal bar while swimming at an indoor pool. She developed localized left-sided forehead swelling. There was no loss of consciousness. The next day she was evaluated at an urgent care for complaints of a high fever. She had a positive Rapid Strep® test and was discharged with cephalaxin. She was seen in follow-up by her pediatrician for ongoing fever. At this visit, laboratory studies revealed a leukocytosis. She was sent to the emergency department for evaluation and a non-contrast computed tomography scan of the head was performed that revealed frontal sinusitis. She was discharged home from the ED with levofloxacin and fluticasone with the clinical impression of sinusitis.

The patient returned to the ED one day later with fatigue, weakness and gait imbalance. Per the parent, she could not hold a pen with her right (dominant) hand, had difficulty concentrating and an abnormal gait. On neurologic examination, the patient was alert and oriented to person, place and situation. There was a swollen non-tender mass at the center of her forehead. She had a right lateral gaze, but otherwise cranial nerves II-XII were intact. Dysmetria was noted during finger-nose-finger test. Deep tendon reflexes were unremarkable. The patient did not appear to have an abnormal gait on exam.

Given the abnormal neurologic examination, a non-contrast head CT was repeated and revealed a subacute 7 mm left frontoparietal and temporal subdural hematoma with midline shift and frontal scalp soft tissue swelling. The patient was taken to the operating room the same day where a left craniotomy was performed, revealing that the fluid collection was a subdural empyema, not subdural hematoma. The fluid cultured positive for Streptococcus milleri (intermedius). The patient was initially treated with vancomycin and piperacillin/tazobactam, then transitioned to cefepime (dominant) hand, had difficulty concentrating and an abnormal gait. In comparison to the left, she had 4/5 motor dorsiflexion and plantar flexion on the right lower extremity. She had a pronator drift and difficulty with rapid alternating movement of the right upper extremity. She was unable to oppose the right thumb with her index finger. Dysmetria was noted during finger-nose-finger test. Deep tendon reflexes were unremarkable. The patient did not appear to have an abnormal gait on exam.

PPT is rare but has serious implications and clinicians must maintain a high degree of clinical suspicion for the pathology. ²

REFERENCES

**2019 BOARD OF DIRECTORS CANDIDATES**

**ABIGAIL BRACKNEY, MD, FACEP**

- Graduate, Wayne State University School of Medicine, Detroit, MI, 2007
- Emergency Medicine Residency, Henry Ford Hospital, 2007-2010
- Emergency Medicine Ultrasound Fellowship, Henry Ford Hospital 2010-2011
- Attending Physician, Beaumont Hospital - Royal Oak, 2011-present
- Associate Director of Emergency Ultrasound - Beaumont Hospital - Royal Oak, 2011-present
- Core Faculty, Emergency Medicine Residency, Beaumont Hospital - Royal Oak 2011-present
- Assistant Professor, Oakland University William Beaumont School of Medicine - 2011-present
- Course Director of Point-of-care and procedural Ultrasound rotation for MS4 students
- Faculty MCEP Ultrasound Course 2013-present
- MCEP Educational committee - 2017-present
- Co-Director Midwest Winter Symposium 2018-present
- Co-Director Michigan Emergency Medicine Assembly 2019
- Fellow, American College of Emergency Physician
- Diplomate, American Board of Emergency Medicine

Dr Brackney competed her emergency medicine residency and ultrasound fellowship at Henry Ford Hospital in Detroit, MI. She has been working as core faculty and the Associate Director of Emergency Ultrasound at Beaumont Hospital in Royal Oak since completion of her training, where she actively participates in resident and medical student education. She is currently working to expand the ultrasound curriculum at Oakland University William Beaumont School of Medicine and is the course director for a Point-of-care Emergency ultrasound elective for MS4 students. Since 2013, Dr. Brackney has participated in teaching at the MCEP ultrasound course and then became the co-Director of the Midwest Winter Symposium in 2018 and the Michigan Emergency Medicine Assembly in 2019. Dr Brackney has been active in the MCEP Educational committee since 2017. She enjoys teaching and has an interest in resident and medical education and especially ultrasound teaching. Dr Brackney also has an interest in physician wellness and the opioid crisis.

**PAMELA COFFEY, MD, FACEP**

- Graduate, St George’s University School of Medicine, Grenada, 1999
- Emergency Medicine Residency, MSU Sparrow Hospital, Lansing, MI, 2002
- Pediatric Emergency Medicine Fellowship, Children’s Hospital of Michigan, Detroit, MI 2004
- Attending Physician, Sparrow Hospital, Lansing MI 2005-present
- Attending Physician, Hurley Medical Center, 2006-2012
- Clinical Instructor in Emergency Medicine, Hurley Medical Center, University of Michigan, Flint, MI 2006-2012
- Clinical Assistant Professor, Department of Emergency Medicine, Michigan State University College of Human Medicine, Lansing, MI, 2016-present
- Core Teaching Faculty, Michigan State University Emergency Medicine Residency, Sparrow Hospital, Lansing, MI, 2017- present
- Member American College of Emergency Physician Pediatric EM Section 2000-present
- Member American Academy of Pediatrics Emergency Medicine section, 2006-present
- Graduate MCEP Leadership Development Program, 2016

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**Save the Date**

**May 30 – June 2, 2019**

**Emergency Medicine Restorative Retreat**

Join us at the Crystal Mountain Resort in Thompsonville, MI for a restorative family-friendly weekend focused on wellbeing and developing approaches to promoting personal & professional health and fulfillment.

- Keynote Speaker: Heddy Wald, PhD - Alpert Medical School, Brown University
- Mindfulness & Resilience Retreat: Professional coaching, “Keeping a Schedule When You Don’t Have One”
- CME
- Family BBQ and Campfire
- Yoga, Meditation, Hiking, Mountain Bike Ride, Music & Art Therapy, MMA Fitness, Guided Journeys Art Park, Salsa Making, & much more.
Dr. Coffey has been a member of MCEP since joining as a resident in 2000. She became actively involved in the chapter when she completed the Leadership Development Program in 2016. Since then she founded and is currently co-chairing the Pediatric Committee and was actively involved in the Mind Mi Head campaign in 2018. She recently started the Kids Korner column in the MCEP newsletter with a goal of helping EM physicians tackle the unique challenges that pediatric patients bring. She participated in the 2019 Wellness Conference planning committee. Additionally she is currently involved with 3 separate Michigan DHHS workgroups to help develop statewide policies. She is a regular lecturer with the MSU EM residency. Her interest is primarily pediatric emergency medicine education, but also is interested in public health issues, particularly as they apply to Emergency Medicine. As an MCEP board member, she will work hard to help contribute to the exceptional work already in place by the current board to advance the specialty of Emergency Medicine.

MICHAEL GRATSON, MD, MHSA, FACEP

- Founding Co-chair, Pediatrics Committee, Michigan College of Emergency Physician, 2017-present
- Fellow, American College of Emergency Physicians
- Diplomate, American Board of Emergency Medicine for EM
- Diplomate, American Board of Emergency Medicine for Pediatric EM

Dr. Gratson first became involved in MCEP while during his residency in 2012. He first became members of the Health Finance and Legislative Committees and continues to serve to this day. Dr. Gratson has completed the Leadership Development Program and in 2017, was elected to the Board of Directors by a special election. He has been active legislatively both on the local and national level to improve the conditions for both those who work and those who receive care in an emergency medical setting. Recently, Dr. Gratson has completed a Masters in Health Services Administration to better understand the complexities of the current health care delivery system. Dr. Gratson aims to continue his work on the Board of Directors and the Health Finance Committee improving physician reimbursement and improving the conditions in which emergency physicians work and our patients receive their care.

DIANA NORDLUND, DO, JD, FACEP

Emergency Care Specialists, Grand Rapids, MI
Corporate Compliance Officer and ED Physician
Nordlund | Hulverson, PLLC
Attorney and Partner

Education
- Bachelor of Music, Western Michigan University, 1998
- Master of Music, University of Illinois at Urbana-Champaign, 2000
- Doctor of Osteopathic Medicine, Kirksville College of Osteopathic Medicine, 2006
- Emergency Medicine Residency, Metro Health Hospital, 2010
- Osteopathic Internship, 2007
- Juris Doctor, Thomas M. Cooley Law School, 2012

Work History
- Emergency Department Attending Physician
  - Emergency Care Specialists, Grand Rapids, 2017-present
  - Corporate Compliance Officer, 2019-present
  - Deputy Compliance Officer, 2017-2019
  - Corporate Compliance Officer, 2014-2017
  - Core Faculty, MSU EM Residency, Lansing, 2015-2017
  - EPMG, Lakeland Health, St Joseph, 2010-2013
- Associate Attorney, Henn Lesperance, PLC, 2014-2016
- Medical Legal Committee, ACEP, Sub-Chair and Member, member since 2011
- State Legislative Committee, MCEP, Vice-Chair and Member, member since 2015

A diplomate of the American Board of Osteopathic Emergency Medicine, Fellow of the American College of Emergency Physicians, and member of the State Bar of Michigan, Dr. Nordlund practices both emergency medicine and the law. After several years of legal practice in medical malpractice defense and health law, her legal work now focuses on physician contracts, consulting, and outside counsel resources for medical practice defendants. Anchored by the belief that legislative advocacy and a proactive, forward-looking approach to further strengthening the profession of Emergency Medicine and the people who practice it, Dr. Nordlund deeply appreciates MCEP’s many years of dedication to the profession and would be delighted to serve a second term on the Board.

www.mcep.org
The Salter-Harris classification of epiphyseal fractures is a classic. It is on every emergency board exam and presented at every pediatric orthopedic talk. So, what do emergency physicians need to know about this classification scheme? Let’s see…. 1) Orthopedists use it to predict outcomes and surgical interventions. 2) In most instances emergency physicians refer fractures to orthopedists. Maybe the classification system isn’t very important to us. Except….the type-1 fracture. The problem with the type 1 fracture was originally described in Salter and Harris’s landmark article.1 While the deforming force is being applied, the bones displace. When the deforming force is removed, the bones may return to their original positions. Thus, a Salter-Harris type 1 fracture through the physis might appear entirely normal in the x-ray. A dilemma for us all.

How have emergency physicians dealt with this dilemma? They used the physical examination to guide them. If the point of maximum tenderness was directly over the physis, a type 1 fracture was assumed to be present and the patient was treated accordingly. That usually meant a cast and referral to the orthopedist: inconvenience, expense, and time spent obtaining medical care for the patient.

Boutis, et al.2 rocked my world and—whether you know it or not—maybe yours also. They collected 130 children who were thought to have a Salter-Harris type 1 fracture by history and physical examination. These patients were treated with an air splint and activity as tolerated—this is the usual treatment at Toronto Hospital for Sick Children as discussed in a 2007 article.³ All the children had an MRI a week later as part of the study. The MRI results were not available to the orthopedist until the 4-week visit. The results?….Only 4 children had MRI evidence of a physeal fracture and all of those were associated with significant ATFL (anterior talofibular ligament) tears. There was no difference in outcomes at 1 and 3 months in those with and without type 1 fractures!

RECAP! Applying the usual definition of Salter-Harris type 1 fracture of the distal fibula, 130 children had a type 1 fracture. When checked by MRI, only 4 actually had the problem and the patient outcomes were the same as those without a fracture.

Additional information that was gleaned from this article: The MRI showed 38 patients with a cartilage avulsion associated with severe ATFL tears. They had also been treated with an air splint and activity as tolerated. The results?….Yes, you guessed it. No difference in outcomes at 1 and 3 months.

RECAP: The MRI showed lots of lesions but there was no difference in patient outcomes.

Did you feel the earth move under your feet? (Please use Carol King’s tune.)

Wait, before we get too excited let’s put this in context. Although this is compelling evidence of a lack of type 1 fractures of the distal fibular physis, it may not apply in other joints. There may be something special about the distal fibula. Further studies of other joints are needed to see if this information is generalizable.

Nevertheless, if it looks like a duck and walks like a duck… its a sprain. Salter-Harris type 1 fractures of the distal fibula are—for all intents and purposes—nonexistent.

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   Injuries Involving the Epiphyseal Plate
   JAAOS  1963, 45-A; 587-621

2) Boutis K, et al.
   Radiograph-Negative Lateral Ankle Injuries in Children
   Occult Growth Plate Fracture or Sprain?
   JAMA Pediatrics Published online January 4, 2016

3) Boutis K, et al.
   A Randomized, Controlled Trial of a Removable Brace Versus
   Casting in Children With Low-Risk Ankle Fractures
   PEDIATRICS Volume 119, Number 6, June 2007
2019 EMRAM SIMWARS AND RESEARCH DAY WINNERS

Congratulations to the 2019 SIMWARS Champions:

1st Place - St. John Medical Center- Ascension:

Kevin Chang, MD
Marc Goulet, MD
Shawn Munafo, MD
Joseph Sheets, MD

2nd Place - Ascension Genesys Hospital:

Ben Khuc, DO
Matthew Ullrich, DO
Heather Bick, DO
Avneet Nijjaar, MD

Congratulations to the following 2019 Research Winners:

Best Oral Presentations:

Kyle Nedic, MD – Ascension St. John Hospital

Best Poster Presentation:

Nhat Trinh, MD – Michigan State University/Sparrow Hospital – Lansing
Executive Committee
Rami Khoury, MD, FACEP — President  
apresident@mcep.org
Warren Lanphear, MD, FACEP — President-Elect  
Nicholas Dyc, MD, FACEP — Treasurer  
Gregory Gafni-Pappas, DO, FACEP — Secretary  
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