MCEP
ADVANCING EMERGENCY CARE

News & Views

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EXECUTIVE LEADERSHIP UPDATE FROM THE PRESIDENT

As of February 14, Executive Director Belinda Chandler is no longer with the College. We thank Belinda for the good work she has done for MCEP and wish her well on her future endeavors. As we plan for the future, we are working actively on a smooth transition. There will be no disruption to the activities of the college.

Christy Snitgen has accepted the role of Interim Executive Director. With her 27 years of service to the College, she has extensive knowledge of the internal workings, people, and spirit of the College and is uniquely poised to make this transition as smooth as possible. We deeply appreciate her willingness to step up in this role. As always, you can reach Christy at csnitgen@mcep.org.

We know that many of you have questions and thoughts regarding the future of MCEP. A series of town hall meetings will be announced soon to start this discussion and keep the dialogue open so that all members can be heard and kept updated. Updates will also be distributed via email as we progress throughout the process. In addition to the town hall forum, you may bring questions about the future and share your vision for the College with myself, the other Executive Officers, or any member of the Board of Directors.

Thank you for your patience as we work together for the future of MCEP.

Gregory Gafni-Pappas, DO, FACEP
President
Michigan College of Emergency Physicians

In This Issue

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Gregory Gafni-Pappas, DO, FACEP

"It was great seeing so many colleagues and their families at MCEP's Boyne Mountain Winter Symposium at the end of January. The slopes were packed with great snow, and the lectures were top-notch. Even with Omicron still center stage, we were able to hold a safe and informative meeting, while having fun with family and friends. Thank you to all our meeting attendants and our sponsors for making this another great event."

4 From the Editor and Guest

Sara Chakel, MD, FACEP

"Once upon a time, sometime in the last millennium, an eager young person decided to pursue medicine. As she matriculated through medical school, she found herself drawn, over and over, to the acute cases, those in which seconds and minutes mattered, those in which fast thinking and a calm demeanor could mean the difference between life and death. That person was me, and I picked emergency medicine to become that type of calm and collected doctor with a broad fund of knowledge and the ability to take care of anyone, anywhere, anytime."

Michigan Emergency Medicine News & Views is the official publication of the Michigan College of Emergency Physicians. Deadline for publication of all letters/articles is the 5th of the month prior. All correspondence should be addressed to MCEP News & Views, 6647 West St. Joseph Hwy., Lansing, MI 48917. Telephone (517) 327-5700, FAX (517) 327-7530, www.mcep.org. Opinions expressed within this newsletter do not necessarily reflect the College's point of view. While News & Views believes that the ads it accepts originate from reputable sources, it takes no responsibility for the consequences resulting from, or the responses generated by, any commercial or classified advertisement.

5 Legislative Column

Bret Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates

"On paper, the Michigan Legislative session begins the second Wednesday of each year. In practice, the real work of Michigan's Senators and Representatives starts after the Governor's State of the State (SOTS) speech. Given the current state of the Omicron variant, the decision was made by the Governor's office, in conjunction with House leaders, to do the SOTS virtually. Because the SOTS was not in person at the Capitol complex, the Governor used the opportunity to give the speech from Detroit Diesel in the City of Detroit."

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Don H. Powell, DO, FACEP

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Laura Seewald, MD and Patrick Carter, MD

"Firearm injuries are the second leading cause of death among U.S. children and teens (age 1-19 years old), with 3,400 deaths and approximately 18,000 non-fatal firearm injuries occurring each year. Among pediatric firearm fatalities, 59% result from homicides, 35% result from suicides, and 4% result from unintentional or "accidental" injuries."

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Submissions to the March/April 2022 Newsletter should be received by the Chapter office no later than March 20, 2022.

VIOLENCE IN THE ED, WELLNESS, AND PSYCHIATRIC BOARDING

Gregory Gafni-Pappas, DO, FACEP

It was great seeing so many colleagues and their families at MCEP's Boyne Mountain Winter Symposium at the end of January. The slopes were packed with great snow, and the lectures were top-notch. Even with Omicron still center stage, we were able to hold a safe and informative meeting, while having fun with family and friends. Thank you to all our meeting attendants and our sponsors for making this another great event.

MCEP had its traditional board meeting during the conference. Discussion was robust including multiple hot topics. Our lobbyist, Bret Marr, had good news regarding the introduction of our House bills to curb violence in the emergency department. We are hoping to get more traction with this bill, given recent upticks in healthcare violence over the course of the pandemic. According to the AMA, "recent surveys [have indicated] at least one-quarter of reporting U.S. physicians having experienced attacks or harassment on social media." Some are serious enough to include death threats. Furthermore, physical violence in healthcare has also increased in the same period. Many of us have noted increased violence in our EDs. Our bill aims to increase fines for violence against healthcare workers in emergency departments and to require preventive signage around EDs. This is only the first step we are taking at a legislative level. We will continue to work on even more robust strategies that can be implemented in the future, as there is much more work necessary to solve this problem. This includes the development of data collection systems to track verbal, written, and physical violence, better security protocols, and increased healthcare organization prevention advocacy. MCEP will continue to fight for the safety of our physicians and all emergency personnel we work with in the emergency department.

Violence in the ED is just one of many factors affecting emergency physician wellness and mental health over the course of the pandemic. Long wait times in the ED, staffing shortages, and ED boarding have also increased burnout and exhaustion in our specialty. The Lorna Breen Healthcare Provider Protection Act passed in 2021 and includes multiple grants and resources to promote the development of evidence-based strategies to improve physician wellness and prevent suicide in healthcare. These actions are much needed, not only in our specialty, but in the house of medicine. Physician wellness is a priority for ACEP and MCEP alike.

On a similar note, national data across the country demonstrates that psychiatric illness has been on the rise during the pandemic. While we strive to provide the best care for psychiatric patients in the ED, we are not psychiatrists and do not treat chronic psychiatric illness. It is frustrating and disheartening when we cannot find a bed for our vulnerable psychiatric patients that board in our emergency departments, sometimes for days on end. While the system is fraught with problems, we endeavor to do what is best for our patients and that means getting them definitive care with a psychiatrist.

Enter OpenBeds.

OpenBeds is a new cloud-based system in Michigan that will be used to place psychiatric patients across the state. The system aims to improve communication between referring and receiving facilities and to facilitate rapid referrals and transfers. When the system is optimized, psychiatric facilities will be able to report out the number of beds available in real-time or close to real-time. Referring facilities, like EDs, can then go on OpenBeds, see where beds are available, and complete referrals quickly. One patient referral can be sent to multiple psychiatric facilities with closed loop communication back to the referring facility. OpenBeds has been used successfully in other states and has shown great promise in reducing patient wait times in EDs. They will be working with the Michigan Department of Health and Human Services to roll this out throughout Michigan. MCEP has been at the table helping OpenBeds to best implement their system. We hope this will immensely help EDs to improve care for psychiatric patients across Michigan.

MCEP has been busy advocating for our members and our patients. If there is anything MCEP can do to help your practice, please contact us at mcep@mcep.org. Only by engaging and confronting these problems head on can we make a difference in our specialty. Thank you for all you do to advance emergency medicine in Michigan. §

www.mcep.org

2022 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 2022 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 on Mackinac Island at the end of July. **Four** 3-year posts on the Board are open for election this year, with three incumbents.

Those interested in Board service should e-mail their notice of intention to the Chapter office, mcep@mcep.org, no later than **March 1, 2022**. Please include with your notice a brief biographical sketch, a copy of your curriculum vitae, and your preferred contact information. Thank you!

REFLECTIONS AS MATCH DAY APPROACHES

Sara Chakel, MD, FACEP

Once upon a time, sometime in the last millennium, an eager young person decided to pursue medicine. As she matriculated through medical school, she found herself drawn, over and over, to the acute cases, those in which seconds and minutes mattered, those in which fast thinking and a calm demeanor could mean the difference between life and death. That person was me, and I picked emergency medicine to become that type of calm and collected doctor with a broad fund of knowledge and the ability to take care of anyone, anywhere, anytime. If that sounds idealistic and perhaps a touch unrealistic, it most certainly was, but it's something I reflect upon from time to time.

This is the time of the year when fourth year medical students have finished their interviews, and both medical students and residency programs are preparing rank lists. As we move through whatever wave of the pandemic we are in now, I think back to when I was preparing my own rank list nearly 20 years ago. So much has changed, and, yet, so much remains the same. As I started residency, SARS-CoV, the first coronavirus, had just emerged. I remember being fearful of exposure, yet eager to do my part if this virus came to Michigan. Fortunately, it never got closer than Toronto, and the world would have 16 years before the emergence of SARS-CoV2 and the current pandemic. At times, I think about how different a medical school experience our future EM interns have had compared to my medical school experience. Over half of their medical school experience has been during this pandemic. Nevertheless, they have persisted, selected emergency medicine, and maintain much of the idealism of students with all the possibilities of the world of medicine opening in front of them.

This year in particular, with the Olympics in full-swing and the Superbowl recently played, I think as well about how well-trained emergency physicians are truly a unique breed, both in terms of scope of knowledge and ability to quickly identify the heart of a problem. This may sound extreme, but the skill set we possess, and the training that we undergo to learn this knowledge, is not dissimilar to that of athletes such as Olympians or professional athletes who have trained for many years to use their skills on the greatest stages in the world. Taking into account medical school and residency, emergency physicians give seven or eight years of their lives to master the skills needed to be the first point of contact in the hospital system for patients presenting with acute illness.

With this in mind, let's reflect on lessons learned and lessons we can take forward to the newest members of our specialty. Put another way, I want to think about what I would have told a younger version of myself about what is so great about our specialty and what to look for in a future career. At the beginning, I would tell myself that it is okay not to know all the answers, as long as you know how to get your questions answered. I worried about diagnostic and management uncertainties a lot in training, and it took me several years in practice to be comfortable with not knowing and with trusting my instincts. In the emergency department, we always have resources to call upon when we don't know the answer, whether that involves consulting a specialist, calling the primary care provider, looking something up, ordering additional testing, or even just bouncing a case off a colleague for another opinion. This lesson can be summed up as being comfortable with not having all the answers but knowing where to go to find them.

To these soon-to-be residents, I would also brag about the unique skillset that they are about to acquire. When there is a call for a doctor on a plane, the flight attendant is looking for someone with our knowledge and skills, someone who can quickly distinguish sick from not sick, someone who remains calm under pressure, someone who can make do with limited supplies and resources. We are truly the experts in doing more with less, whether it be less space/rooms (hello, hallway beds and waiting room evaluations), variations in nursing and other support staffing, shortages of anything from normal saline to basic medications, or any other random occurrence. We make the system work, as best as we can, for our patients, time and again. This is something that we can all be proud of.

As these medical students prepare their rank lists and await Match Day, I would tell them to never lose sight of the person they are outside of medicine. Maintain relationships with friends and family, and don't neglect personal health and well-being while in residency and beyond. Wellness is not something that I talk about lightly, and achieving personal wellness in the face of the enormous stress of residency, not to mention practicing emergency medicine in 2022, can be challenging, but wellness must be a focus. Read a book, just for fun, from time to time. Take a class to learn something new, even if the shift schedule inherent in emergency medicine means that attending every lesson will not be possible. Focus on healthy eating, staying active, and sleeping to stay as rested as possible, time permitting. Don't neglect personal health and well-being in favor of training or your job. Being a good doctor and a well physician are complementary, and not mutually exclusive, goals.

My final thought about these incoming, soon-to-be-matched, emergency physicians of tomorrow is that those of us in residency programs have a great responsibility to train them well. They are the future leaders in our specialty, and they will be the doctors caring for us and our loved ones in the future. As we prepare our rank lists and eagerly await Match Day, let's also remember when we were at the same position they are now in, ranking programs and waiting to find out where we would train. Let's capture a little bit of that idealism and bring it forward to the next generation of emergency physicians. What we do makes a difference, and it will be a great privilege to welcome the next class of EM physicians to our ranks a few weeks from now. §

2022 LEGISLATIVE SESSION AND ELECTION CYCLE STARTED

Bret Marr
Muchmore Harrington Smalley & Assc.

On paper, the Michigan Legislative session begins the second Wednesday of each year. In practice, the real work of Michigan's Senators and Representatives starts after the Governor's State of the State (SOTS) speech. Given the current state of the Omicron variant, the decision was made by the Governor's office, in conjunction with House leaders, to do the SOTS virtually. Because the SOTS was not in person at the Capitol complex, the Governor used the opportunity to give the speech from Detroit Diesel in the City of Detroit.

Her speech focused on economic development efforts by the state and efforts moving forward on electric vehicles (EV), including a tax credit for purchases of EVs. She also proposed an elimination of the state's pension tax, an item she campaigned on in 2018. She focused on her efforts to dramatically increase funding for the state's education system, a point that was reflected in her budget proposal from early February. Lastly, she spent ample time talking about the need for mental health resources, focusing on both affordability and access to sufficient practitioners to provide needed care for a struggling society.

MICHIGAN'S REDISTRICTING PROCESS

MHSA and MCEP are providing this to members because of the number of questions about all the press surrounding this issue. In 2018, Michigan voters amended the State Constitution to require an Independent Citizens Redistricting Commission to draw the State's Congressional seats, State Senate seats, and House of Representatives maps. This process played out in 2021 through multiple public hearings around the state and produced final maps in late December. These maps are currently being litigated in state and federal courts but will be close to the maps below. Recall that because of population decline, Michigan lost one Congressional seat and is down to 13 members of the U.S. House, down from a high of 16 seats a few decades ago.

For those of you having trouble sleeping, here's a link to the final maps for Michigan's Congressional, State Senate, and State House maps: https://www.michigan.gov/micrc/0,10083,7-418-107190_108607--,00.html. Historical note, each map version is named after a species of Michigan tree.

VIOLENCE IN THE EMERGENCY DEPARTMENT

MCEP is again working with MSMS and other health care groups to raise awareness of unnecessary violence in the Emergency Department (ED) workplace. We are supporting House Bills 5084 and 5682 in the House Government Operations Committee. A preliminary hearing was held in late January on the bills, and the committee will take action later this month on proposed changes. One of the changes coming will be to reduce the crime being proposed from a felony to a 93-day misdemeanor. This increases current penalties but addresses legislative concerns about creating new felonies. Other changes being contemplated are increasing the fines for assault to $2,000 from the current $500 level. Lastly, the enhanced penalties and fines would not apply to patients, but to loved ones or family members in the ED. MCEP and MHSA will keep you posted as this legislation moves through the process. §

POTENTIAL 2023 CODING AND DOCUMENTATION CHANGE

Don H. Powell, DO, FACEP

The recent changes in the 2021 coding guidelines for office and other outpatient E/M procedure codes was the biggest update in years. With these changes came a collapse of the outpatient code set, with new emphasis on medical decision making (MDM) and the element of time. Several emergency medicine organizations (ACEP/EDPMA) have lobbied hard against the collapse of our code set and instituting the element of time into our emergency medicine reimbursement guidelines. There have been strong suggestions that, in 2023, these same changes may be applied to all other evaluation and management categories. Currently, it is unclear if there will be exact or similar guidelines and what type of effect these guidelines will truly have on the billing and coding of emergency medicine.

With the different initiatives and the push for patients over paperwork, providers may initially be excited by the thought that the history (HPI) and physical exam (PE) documentation requirements may lessen. Unfortunately, even if the HPI and PE documentation requirements go away for reimbursement purposes, medico-legal requirements will continue to necessitate similar documentation practices. The emphasis on quality of documentation, especially the MDM, will be paramount.

Currently, there are a few differences in the CMS and CPT guidelines, but many of these inconsistencies may be alleviated if the 2021 changes or a version of the 2021 changes are applied to all evaluation and management categories. Unfortunately, there will always be the individual commercial insurers that will try to institute their own interpretations regarding these coding rules. The more consistency there is between CMS and CPT, the easier it will be to appeal these claims and use this uniformity to dispute different claim rejections.

For 2023, major changes in documentation are coming. It's possible that 100% of coding will be based on the MDM. Key elements for providers to amplify in their MDM charting should include:

- Differential diagnosis
- Labs, imaging, EKGs, and other testing ordered, with commentary on pertinent positive or negative results
- Medications given, including routes, repeat dosing, and response
- Discussions with family, EMS, primary care physician, consultants, and admitting teams
- Critical care time, if applicable
- Follow up timing and plans
- Discharge medications
- Discussion on admit/discharge decision making
- Discussion of potential reasons studies were not ordered (e.g., PECARN), as points will be awarded for consideration of studies §

Don H Powell, DO, FACEP
Emergency Care Specialists- Director Reimbursement and Advocacy
Medical Management Specialists- President

MCEP Calendar of Events

March 2, 2022
Board of Directors
Chapter Office
Lansing, Michigan

March 30-31, 2022
Critical Care in the ED Conference
Virtual Zoom Meeting

April 21, 2022
MCEP Legislative Day w/ LDP
Capitol Building
Lansing, Michigan

May 1-4, 2022
ACEP L&A Conference
Washington, DC

May 11, 2022
Board of Directors
Chapter Office
Lansing, Michigan

May 21, 2022
Mock Oral Board Review Course
Virtual Zoom Meeting

July 31- August 3, 2022
Michigan Emergency
Medicine Assembly
Grand Hotel
Mackinac Island, Michigan

August 1, 2022
Board of Directors
Grand Hotel
Mackinac Island, Michigan

August 18, 2022
EM Career Planning:
Life After Residency
Somerset Inn
Troy, Michigan

September 7, 2022
Board of Directors
Chapter Office
Lansing, Michigan

September 15-16, 2022
Observation Medicine Conference
Location TBD
Nashville, Tennessee

September 20, 2022
MCEP Councilor Meeting
Chapter Office
Lansing, Michigan

September 29-30, 2022
ACEP Council Meeting
San Francisco, California

October 1-4, 2022
ACEP Scientific Assembly
San Francisco, California

November 15, 2022
$traight Talk
Reimbursement Course
Location TBD

December 7, 2022
Board of Directors
Chapter Office
Lansing, Michigan

FIREARM SAFETY RESOURCES FOR HEALTHCARE PROVIDERS AND PARENTS

Laura Seewald, MD

Patrick Carter, MD

Firearm injuries are the second leading cause of death among U.S. children and teens (age 1-19 years old), with 3,400 deaths and approximately 18,000 non-fatal firearm injuries occurring each year. Among pediatric firearm fatalities, 59% result from homicides, 35% result from suicides, and 4% result from unintentional or "accidental" injuries. Firearm fatalities among pediatric populations have also been increasing, with a 37% increase in firearm homicides and a 48% increase in firearm suicides during the past decade. While firearm fatalities affect pediatric populations in all communities (rural, urban, suburban) at equivalent rates, disparities exist with regards to injury intent. Firearm homicides and assaults disproportionally affect Black teens residing in urban settings, while firearm suicides and unintentional injuries disproportionately affect White and American Indian/Alaskan native teens residing in suburban and rural settings. It is also important to note that while mass and school shootings represent the smallest proportion (<1%) of pediatric firearm deaths, they have been increasing in frequency over the past two decades and have significant psychosocial and emotional impacts for affected families and the surrounding communities. The economic costs associated with the acute medical treatment of pediatric firearm injuries are substantial, approaching nearly $110 million annually before factoring in long-term societal costs (e.g., lost wages/productivity). The elevated rates of fatal and non-fatal injury occurring among children and teens, combined with the human and financial costs of injury, have prompted national medical organizations, including the American College of Emergency Physicians (ACEP) and the American Academy of Pediatrics (AAP), to advocate for healthcare-based solutions that can reduce pediatric firearm injury risk. Given that nearly 800,000 children and teens receive Emergency Department (ED) care in Michigan annually and that prior research establishes that an ED visit can be a "teachable moment" for enhancing safety practices and reducing the potential for harm, there is much that Emergency Physicians can contribute to reducing injury risk among this vulnerable patient population.

Access to an unsecured firearm remains the most significant risk factor for pediatric firearm injury, regardless of intent. In 80% of completed teen firearm suicides, 74% of school shootings, and 90% of fatal unintentional firearm injuries, the firearm was obtained from the decedent's home or the home of a relative. An estimated 34% of all U.S. households with children own or maintain firearms, with 21% of these families reporting that they regularly store at least one firearm unlocked and loaded. In addition, 85% of all firearm homicides and assaults result from handguns. Data demonstrates that teens acquire such handguns from a broad array of sources, including their home, the home of a family member, friends/peers, and/or through trading/buying firearms that have been diverted from the legal market. Addressing firearm access among children and teens remains a key opportunity to reduce the risk for firearm injury and death, regardless of intent.

Given that counseling interventions can be efficacious at increasing locked storage, especially when paired with providing a locking device, increasing healthcare provider counseling of parents has the potential to significantly reduce unsupervised firearm access and associated negative health outcomes. Prior behavioral research has demonstrated that it is

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Thank you for all that you do!

To all of our frontline workers

From all of us at MCEP

MCEP KID'S KORNER *(Continued from Page 7)*

critical that such conversations are approached in a non-judgmental way that establishes a high level of trust with the parent, maintains respect for parental values about firearm ownership, and collaboratively identifies actionable safety steps that the parent can take to reduce injury risk. It is often helpful to discuss a range of measures that parents can use to reduce their child's risk, including storage options (e.g., locking devices, gun safes), options to make firearms not in use less lethal (e.g., removing firearm pins), and/or options for decreasing unsupervised firearm access (e.g., storing offsite, temporary removal). Research has also shown that parents are more receptive to such conversations when healthcare providers demonstrate a working technical knowledge about firearms and storage devices/practices. The University of Michigan has developed a set of free training videos that highlight many of these counseling principles, as well as information about firearms and storage practices to aid clinicians with integrating this type of counseling into their practice.

While counseling of all patients around locked storage practices may be beyond the scope of a routine ED visit, there are several specific cases where ED providers can focus their counseling efforts to reduce injury risk. EDs are an important access point for teens experiencing severe depression and/or suicidal ideation who may be at high-risk for self-inflicted firearm injury. Research among suicide survivors shows that most teen suicidal crises are short-lived, with approximately a third of adolescent suicide attempts occurring on the same day as a crisis (e.g., breakup with partner or fight with parent) and a quarter of survivors of suicide attempts reporting they planned for less than 5 minutes. Given that over 90% of firearm suicide attempts are fatal, preventing firearm access among this at-risk population remains an important upstream preventative action. Counseling patients and their families on methods for ensuring at-risk teens cannot access lethal firearms and/or that firearms are temporarily removed from the home can keep teens safe during the crisis time-period for long enough to access critical mental health services. In addition to addressing household firearm risk, clinicians should also include a focus on addressing the potential firearm risks associated with houses the teen also visits frequently (e.g., grandparents, friend's houses). The suicide prevention resource center has additional training resources for clinicians on best practices in screening and providing lethal means counseling.

Among adolescents (age>10), the majority of firearm injuries treated in ED settings are the result of interpersonal violence. Notably, half of all teens presenting for ED treatment of a violent injury have received treatment in the preceding 12 months (79% for medical reasons). Such adolescents may not regularly attend school or receive primary care, and the ED may be the best opportunity to intervene before they suffer a more severe firearm injury. Evidence-based hospital violence interventions currently exist to help address this risk. SafERteens is an ED-based violence intervention first developed in Flint, Michigan. This program utilizes a single 30-minute therapist-delivered brief intervention combining motivational interviewing and cognitive behavioral skills training to help youth identify positive life goals, understand consequences of fighting, and learn skills to avoid violence. This includes anger management and conflict resolution skills, coping skills, and positive communication. SafERteens has been demonstrated to reduce both non-partner and partner violence involvement for up to a year following intervention delivery. In two subsequent research studies, the program was successfully integrated into routine ED care delivery. More information can be found about the SafERteens program, as well as how to integrate SafERteens into clinical practice, at the website www.saferteens.org.

In addition to practical steps that clinicians can take within their own practice, ED physicians also have an important role as advocates for child and adolescent firearm safety within their own communities. ED physicians can be an important voice in advocating that firearms in their community be safely stored and not accessible to children and adolescents. They can also have an important role in establishing partnerships with local community groups (e.g., hunter safety organizations) to focus on ensuring firearm safety measures that will ultimately lead to less children and teens dying each year from firearm injury. Further, many local police departments offer locking devices (e.g., trigger or cable locks) for free. Project ChildSafe helps clinicians and parents locate these police departments in their area and provides additional safety resources for parents and firearm owners.

While considering all of the above, ultimately the goal of firearm safety counseling is to move families and firearm owners closer to safer firearm storage (e.g., storing firearm unloaded and locked, locking device use). We recommend reviewing the resources above and below to educate yourself and your teams on the ways to help reduce firearm injuries. §

ADDITIONAL RESOURCES:

a. Handouts for parents:
   1. https://www.icpsr.umich.edu/files/facts/parent-guide-home-firearm-safety.pdf
   2. https://www.icpsr.umich.edu/files/facts/COVID-19-Firearm-flyer.pdf

b. Training videos and online learning for clinicians:
   1. https://www.icpsr.umich.edu/web/pages/facts/training-videos.html
   2. https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means

c. Free firearm safety device locator: https://projectchildsafe.org/

d. Upstream projects: safERteens- https://youth.gov/content/saferteens

Patrick M. Carter, M.D.
Co-Director, Institute for Firearm Injury Prevention
Director, University of Michigan Injury Prevention Center
Leadership Team, Firearm Safety Among Children & Teens (FACTS) Consortium
Associate Professor, Department of Emergency Medicine, School of Medicine
Associate Professor, Department of Health Behavior & Health Education, School of Public Health

Laura Seewald, MD
UM Injury Prevention Center and Firearm Safety Among Children and Teens (FACTS) Consortium Postdoctoral Fellow, 2021-2023
Department of Emergency Medicine, Clinical Lecturer

SUDDEN ALLERGY TO COLD TEMPERATURES: WINTER IS COMING

Nicole Schnabel MD and Bradley Lepore MD from Ascension St. John Hospital, Detroit, MI

INTRODUCTION

We report the case of a mid-30s male patient presenting to the emergency department (ED) with a sudden allergy to cold temperature. Cold urticaria is characterized by the development of wheals, angioedema, or both in response to cold exposure. It can present with or without anaphylaxis.[1] Emergency medicine physicians, especially those practicing in cold climates, should be familiar with this disease and its treatment options given the profoundly negative impact it can have on patients' quality of life.

CASE

The patient is a mid-30s male with no medical history presenting to the ED for evaluation of an episode of swelling, erythema, and shortness of breath after swimming in a lake. The patient states that he and his wife went out on their boat to enjoy the Michigan fall weather. Within minutes of entering the waist high water, the patient noticed his body had become red and swollen. The patient exited the water and immediately experienced palpitations and shortness of breath. The patient's wife stated he became pale and passed out on their boat. The patient woke quickly and was immediately alert. He drove their boat to shore and decided to seek care in the ED.

In the ED, a complete history was obtained. The patient stated he had been experiencing new reactions to cold for the past month. He described redness, swelling, and itching of his hands when he held a cold beverage and similar symptoms involving his face when he felt a cold breeze. The patient stated that even while wearing jeans, his legs would become swollen and red by sitting on a cold bench. The patient endorsed seasonal allergies to pollen, but no other allergies. The patient denied recent travel, sick contacts, or any recent illness including Covid-19.

In the ED, basic bloodwork and inflammatory markers were negative. The patient's symptoms were most consistent with an allergy to cold temperature, and a quick review of the literature revealed the disease of cold urticaria. A cold tolerance test was performed in the ED in which an ice cube was held against the patient's skin for 5 minutes. At the site where the ice cube was held, there was significant erythema and swelling, which is considered a positive test.

The patient was diagnosed with likely cold urticaria. Given he was not currently experiencing symptoms, he did not necessitate intramuscular epinephrine administration. The patient was educated that the mainstay of treatment is allergen avoidance. The patient was given a prescription for loratadine, a second-generation antihistamine, as well as an EpiPen with education on administration. The patient was discharged with referral to an allergist for further workup and monitoring of symptoms.

DISCUSSION

Cold urticaria was first described in 1792, and though it has been reported in pediatric, allergy, and dermatology literature, it has little representation in emergency medicine literature.[1,2] This disease has a prevalence of 0.05%, is seen more often in females, and occurs more frequently in the second through fourth decades of life.[1,3] Cold urticaria is typically characterized by the development of itchy wheals, angioedema, or both in response to cold exposure. Symptoms can also include respiratory distress, hypotension with dizziness, nausea, diarrhea, abdominal pain, disorientation, and shock.[1] Cold urticaria patients have a range of critical temperature thresholds from 4°C to 27°C. Triggers include contact with cold items and low ambient temperatures.[4] Patients experience symptoms 1-5 minutes after exposure

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CALLING ALL INTERESTED RESIDENTS.....

IT IS TIME FOR THE ANNUAL EMRAM OFFICER VIRTUAL ELECTIONS

EMRAM

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 virtually on Wednesday, April 13, 2022. 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 8th. 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. Officer descriptions can be found at www.mcep.org.

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

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with resolution of symptoms generally within an hour.[5] The etiology of cold urticaria remains unknown, although autoallergy, autoimmunity, neurogenic pathways, and aberrant temperature sensing are thought to be possible underlying mechanisms.[6] 50% of patients who acquire cold urticaria will have full remission of symptoms at 5-6 years.[7]

Diagnosis is by a TempTest device or by a cold tolerance test using an ice cube. For the cold tolerance test, an ice cube is placed in a plastic bag, applied to the skin for 5 minutes, and then removed; after 10 minutes, the skin is examined. A positive result is whealing with or without itching in the contact area with the ice.[1] Sensitivity is 83%, and specificity is 100%. A TempTest device is utilized in outpatient settings and generates a temperature range, allowing not only diagnosis of cold urticaria but also determination of critical skin temperature for symptom development.[8] No blood work is required for diagnosis.[9]

The mainstays of treatment are lifestyle modifications and avoidance of cold.[9] Second-generation H1-antihistamines at higher-than-standard doses have been shown to be effective in symptom improvement and complete protection.[10] Current guidelines also recommend prescription of intramuscular epinephrine autoinjector.[1] A randomized placebo-controlled trial demonstrated omalizumab may be efficacious for symptoms.[5] Cold desensitization has shown no benefit.[1]

The hallmarks of cold urticaria management resemble that of other allergic conditions, but emergency medicine physicians should be able to recognize this unique condition given that its triggers are both specific and ubiquitous. Patients, especially those in colder climates, may be justifiably anxious when receiving this diagnosis, and educated physicians will be best equipped to help them understand and manage this disease. §

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