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Judith E. Tintinalli, MD, MS, FACEP

- Professor and Chair Emeritus (1991-2007), Department of Emergency Medicine, University of North Carolina School of Medicine

- Adjunct Professor, Department of Health Policy and Administration, University of North Carolina School of Public Health

- Lecturer, Medical Journalism, University of North Carolina School of Journalism and Mass Communications

Dr. Tintinalli is Professor and Chair Emeritus of the Department of Emergency Medicine at the University of North Carolina at Chapel Hill. She was founding Chair of the department and held the position from 1991 to 2007. The Department of Emergency Medicine has 20 clinical faculty and 2 research faculty, a fully accredited 3 year emergency medicine residency program, and Divisions of Emergency Medical Services and Informatics.

She received her MD from Wayne State University, and completed residency training and received her MPH from the University of Michigan in Ann Arbor.

Dr. Tintinalli was president of the American Board of Emergency Medicine from 1989 to 1990, was the founding president of the Council of Emergency Medicine Residency Directors, and was chairman of the Liaison Residency Committee (forerunner of the ACME sponsored Residency Review Committee). She is editor in chief of the world' s largest selling emergency medicine textbook, *Emergency Medicine: A Comprehensive Study Guide*, in its 6th (2004) McGraw-Hill edition, and co-editor of *Obstetric and Gynecologic Emergencies*, 2nd ed, McGraw-Hill, 2004. She has been both a Board Member, and the Deputy Editor of the Annals of Emergency Medicine. She was elected to the National Academy of Sciences, Institute of Medicine, in 1997, and, in 2005, was a member of the North Carolina Institute of Medicine, Task Force on the Uninsured. She is currently President-Elect of the Association of Academic Chairs of Emergency Medicine and is Editor in Chief of AccessEmergencyMedicine scheduled for release in the fall of 2006.

Stephen H. Thomas, MD, MPH

- Director of Academic Affairs, Massachusetts General Hospital Department of Emergency Medicine

- Associate Medical Director, Boston MedFlight

- Associate Professor of Surgery, Harvard Medical School

Dr. Thomas finished LSU's six-year MD program in 1990, moving to North Carolina to train in Emergency Medicine at East Carolina University. After a fellowship in Air Medical Transport at ECU, he joined the faculty at Harvard and Massachusetts General Hospital. He obtained a Masters in Public Health (Quantitative Methods concentration) at Harvard University in 1999. He has been involved with the EM medical student clerkship at MGH since arriving in Boston, and was a founding faculty member of the Harvard Affiliated Emergency Medicine Residency. He also works at Boston MedFlight, a consortium program sponsored by Boston's Level I trauma centers. Ongoing areas of clinical research include prehospital medicine, analgesia, and evaluation of new technologies in the air medical and ED settings. His professional organization memberships include the Society for Academic Emergency Medicine (SAEM), where he has worked with and chaired the Undergraduate Education Committee. He has also chaired, and continues to serve on, the Air Medical Services Task Force of the National Association of Emergency Medical Services Physicians (NAEMSP). He is currently Director of Academic Affairs in the MGH Department of Emergency Services, and is an Associate Professor of Surgery at Harvard.

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Rita Cydulka, MD, MS, FACEP

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- Associate Professor, Department of Epidemiology and Statistics, Case Western Reserve University

Dr. Cydulka received her MD and completed residency training in Emergency Medicine and Internal Medicine at Northwestern University in Chicago, Illinois. She received her MS from Case Western Reserve University in Cleveland, Ohio.

Dr. Cydulka is Vice-Chair and Associate Professor of the Department of Emergency Medicine at MetroHealth Medical at Case Western Reserve University. She was the founding residency director of the Case Western Reserve University/MetroHealth Medical Center program in Emergency Medicine from its inception until 1999, when she took an academic sabbatical to pursue studies in Biostatistics and Epidemiology/Health Services Research. She is an active contributor to the scientific literature, with over 100 publications in peer review journals and textbooks. Her research interests include emergency treatment of respiratory diseases and health care outcomes. She is a co-editor of *Emergency Medicine: A Comprehensive Study Guide* and is on the editorial board of Annals of Emergency Medicine. She previously served on the editorial board of Academic Emergency Medicine and was a past editor of the Yearbook of Emergency Medicine. She is currently president of the American Board of Emergency Medicine and a member of the National Asthma Education and Prevention Program (NAEPP) Coordinating Committee. She previously served as a member of the Board of Directors of the Society for Academic Emergency Medicine and as a consultant to the Centers for Medicaid and Medicare Services in the development of quality indicators for emergency care.

Matt Lewin, MD, MPH

- Clinical Instructor of Medicine, University of California, San Francisco

- Director of Emergency Medicine Research, University of California, San Francisco

Matt Lewin is an MD, PhD and a Director of Emergency Medicine Research at University of California, San Francisco. He publishes regularly in leading medical journals such as Annals of Emergency Medicine, Lancet and others. He has been named "Top Peer-Reviewer" at Annals of Emergency Medicine for four consecutive years. His interests include fundamental aspects of neurophysiology and pain, travel and expedition medicine. Dr. Lewin is an expedition doctor for the American Museum of Natural History in New York City as well as a house doctor for the San Francisco Opera.

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Figure 19-10 **Cutaneous T cell lymphoma: pagetoid reticulosis** This singular plaque on the abdomen of a 62-year-old male looks like psoriasis but is irregular with notched margins. It was asymptomatic and had been present for 8 months. Histopathology revealed intraepidermal T cells in a pagetoid pattern.

SOURCE: ***Fitzpatrick's Color Atlas & Synopsis of Clinical Dermatology, 5th Edition***

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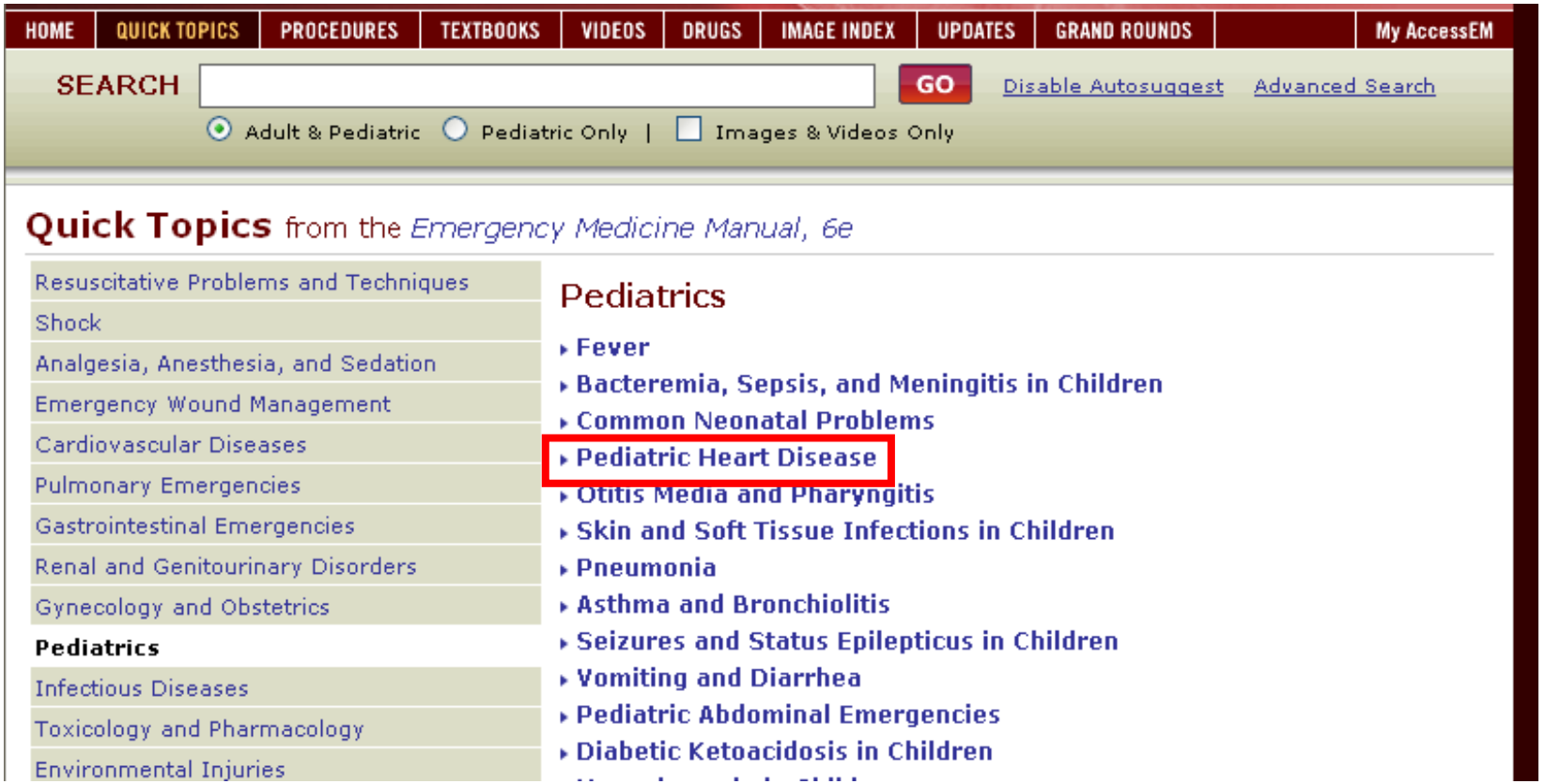

Quick Topics

Chapter 68. Pediatric Heart Disease

David M. Cline

INTRODUCTION

There are 6 common clinical presentations of pediatric heart disease: cyanosis, congestive heart failure (CHF), pathologic murmur in an asymptomatic patient, abnormal pulses, hypertension, and syncope. Table 68-1 lists the most common lesions in each category. Congenital heart disease also may present with shock. Pediatric heart disease is frequently misdiagnosed as a viral upper respiratory tract illness or feeding intolerance. In fact, feeding intolerance may be the first symptom of congenital heart disease. This chapter focuses on conditions producing cardiovascular symptoms seen in the emergency department (ED). These conditions require immediate recognition, therapeutic intervention, and prompt referral to a pediatric cardiologist. Treatment of dysrhythmias is discussed in Chapter 3. Pediatric hypertension is discussed in Chapter 27. Syncope is discussed in Chapter 79.

Table 68-1 Clinical Presentation of Pediatric Heart Disease

Evaluation of an asymptomatic murmur is an elective diagnostic workup that can be done on an outpatient basis. The Still murmur, which is the most common innocent murmur, is early systolic in timing, located at the apex or the left sternal border, and does not radiate. Common pathologic murmurs in children are holosystolic, continuous, or diastolic in timing and usually radiate.

CYANOSIS AND SHOCK

Determining the cause of cyanosis and respiratory distress in the critically ill neonate is difficult. The clinician should consider congenital heart disease, respiratory disorders, central nervous system disease, and sepsis. The hyperoxic test helps to differentiate respiratory disease from cyanotic congenital heart disease (although imperfectly). The infant should be placed on 100% oxygen. Persistence of hypoxemia suggests the presence of a shunt from congenital heart disease.

Clinical Features

An accurate set of vital signs including pulse oximetry and blood pressure is essential. Cyanosis associated with a heart murmur strongly suggests congenital heart disease, but the absence of a murmur does not exclude a structural heart lesion. Early signs of inadequate cardiac output in the neonate may be suggested by slow feeding or tachypnea, diaphoresis, or staccato cough with feeding.

Shock with or without cyanosis, especially during the first 2 weeks of life, should alert the clinician to the possibility of congenital heart disease associated with closure of a patent ductus arteriosus. Neonates with shunt-dependent lesions will experience profound symptoms with closure of the ductus. Shock in the neonate is recognized by inspection of the patient's skin for pallor, cyanosis, and skin mottling and assessment of the mental status appropriate for age. Mental status changes may be fluctuating signs of apathy, irritability, or failure to respond to pain or parents. Tachycardia and tachypnea are commonly present as the initial signs. Tachypnea associated with congenital heart disease is typically effortless, without accessory muscle use commonly seen with respiratory disease. Distal pulses should be assessed for quality, amplitude, and duration, (see Table 68-1).

Diagnosis and Differential

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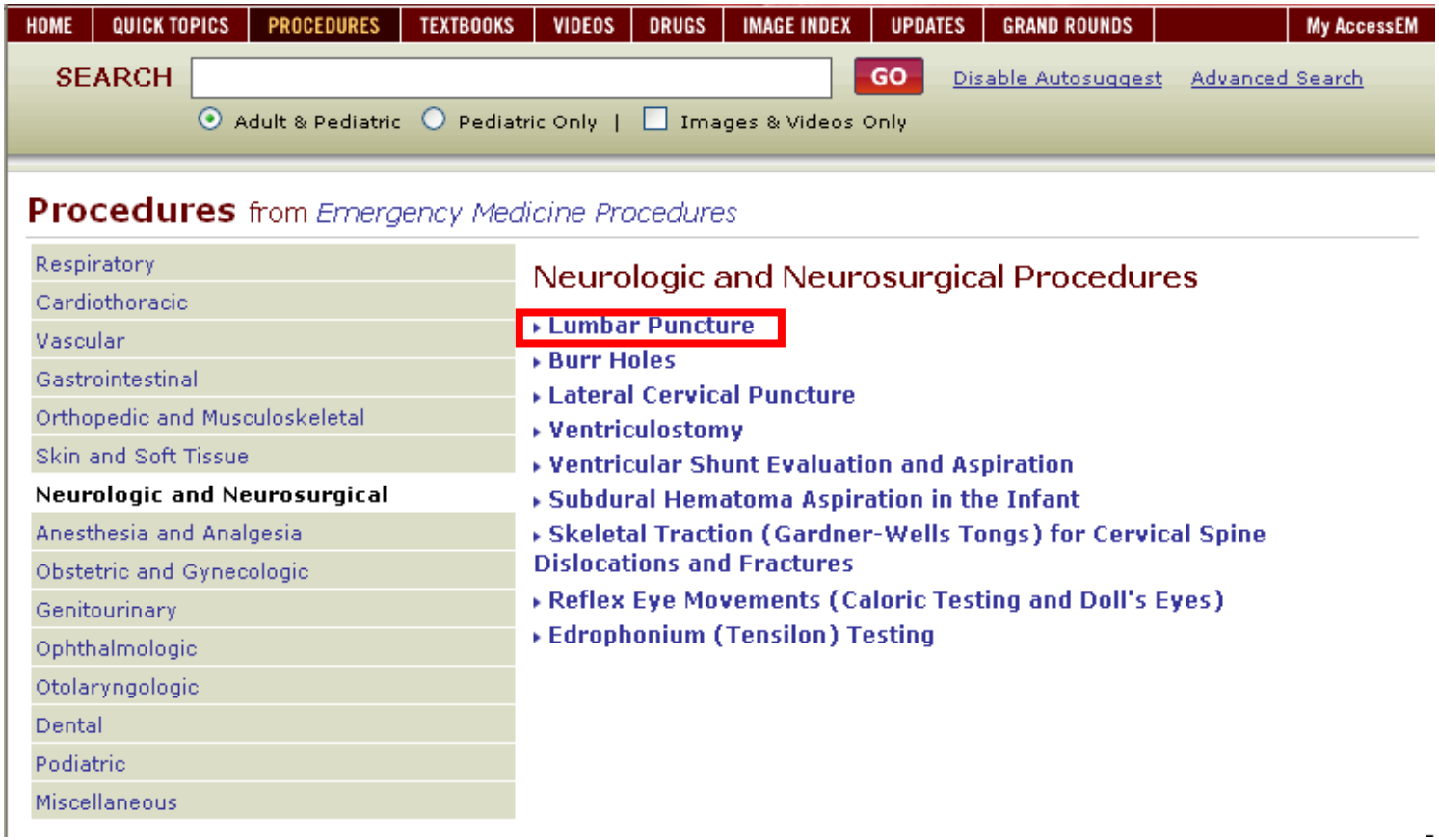
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Reflex Eye Movements (Caloric Testing and Doll's Eyes)
Edrophonium (Tensilon) Testing

Procedures

Chapter 96. Lumbar Puncture

Brian Fong, Jeffrey M. VanBendegom

INTRODUCTION

Meningitis and subarachnoid hemorrhage are serious life-threatening conditions. They require prompt and accurate diagnosis in the Emergency Department due to their significant morbidity and mortality. There are many diagnostic modalities available to the Emergency Physician to assist in the diagnosis. However, lumbar puncture (LP) is still considered the gold standard. Lumbar puncture is a procedure that is often performed in the Emergency Department to obtain information about the cerebrospinal fluid (CSF) to aid in the diagnosis of a variety of medical conditions. Knowledge about the proper indications, contraindications, various techniques, equipment, and recognition and treatment of its complications is vital to any physician that performs this procedure. **A lumbar puncture should be performed after a thorough neurological exam. Significant morbidity and mortality can result if the procedure is performed on the wrong patient.**

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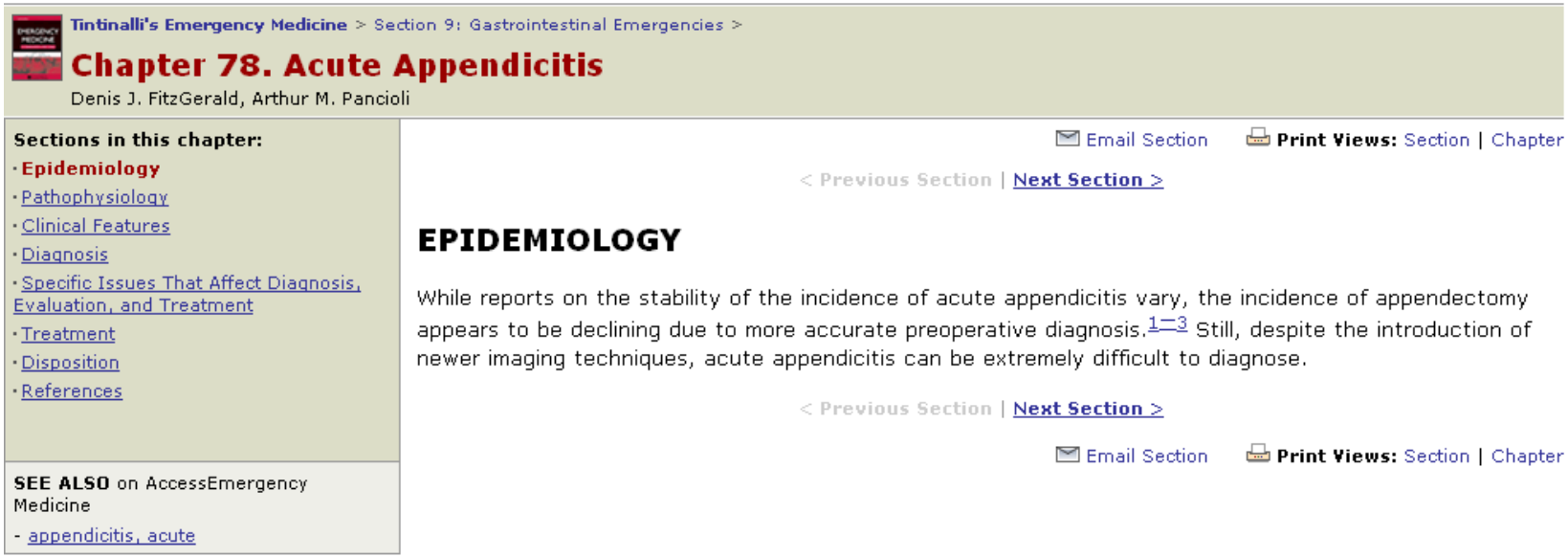

Chapter 78. Acute Appendicitis

Denis J. FitzGerald, Arthur M. Pancioli

EPIDEMIOLOGY

While reports on the stability of the incidence of acute appendicitis vary, the incidence of appendectomy appears to be declining due to more accurate preoperative diagnosis.[1–3] Still, despite the introduction of newer imaging techniques, acute appendicitis can be extremely difficult to diagnose.

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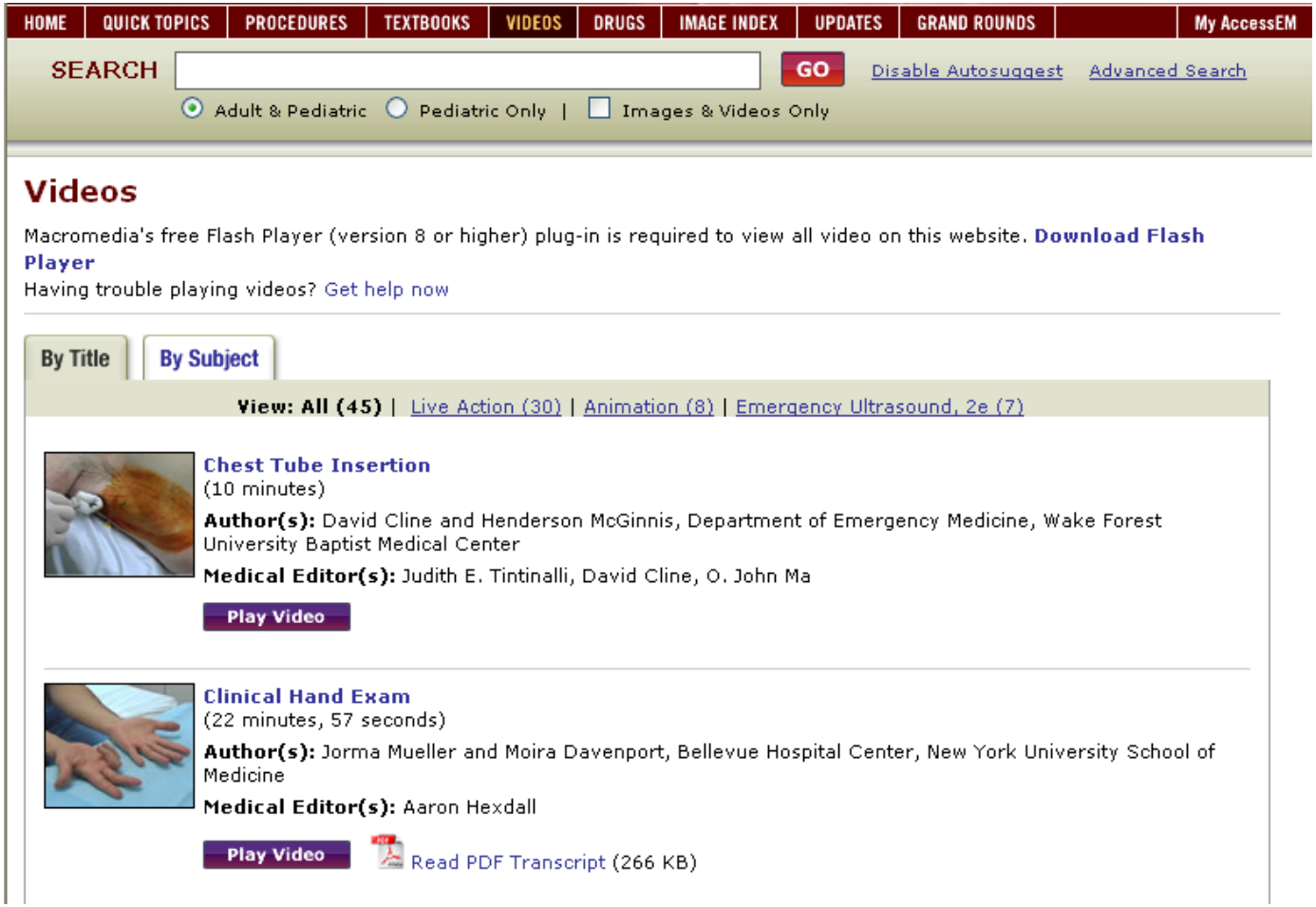
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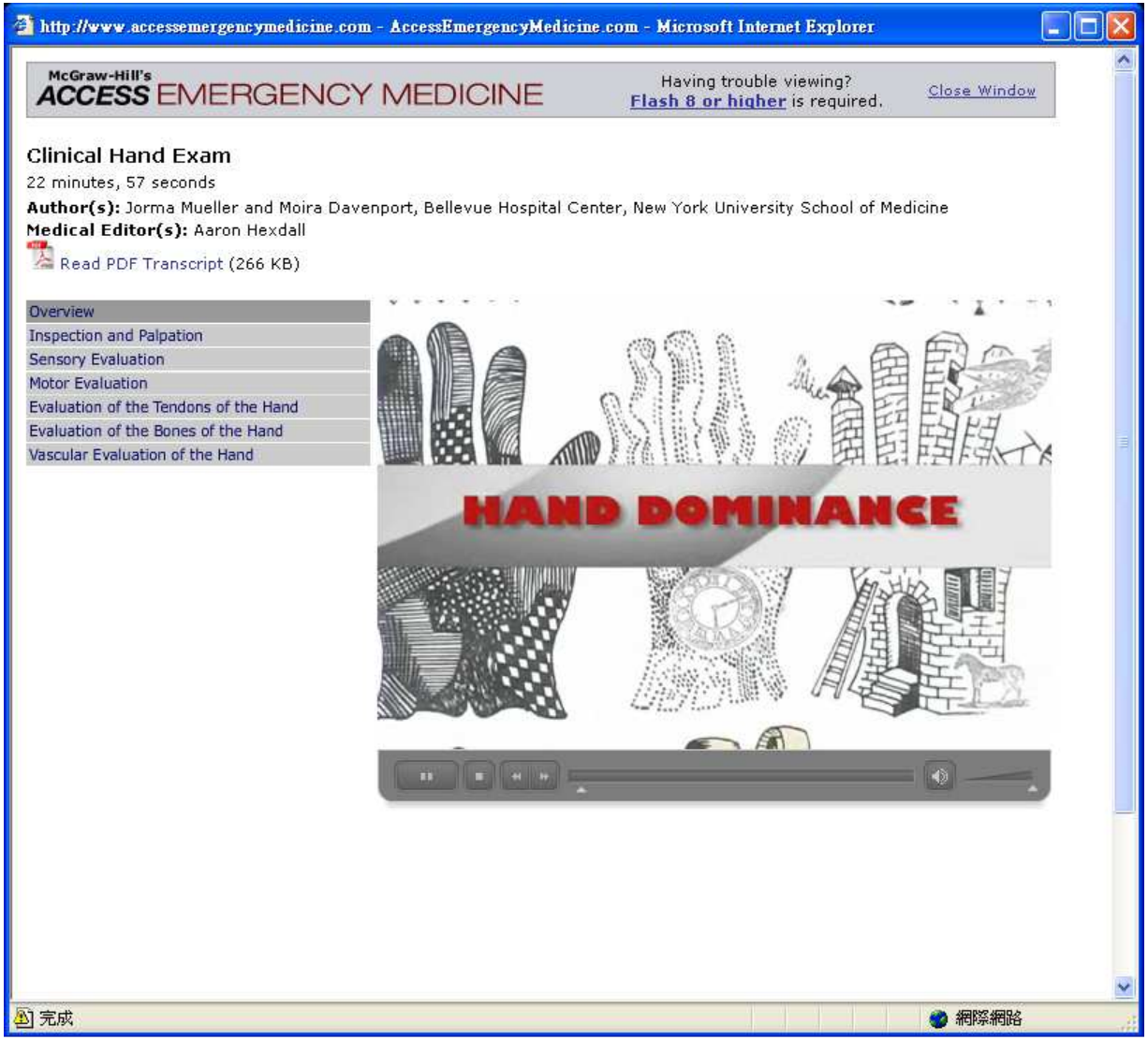
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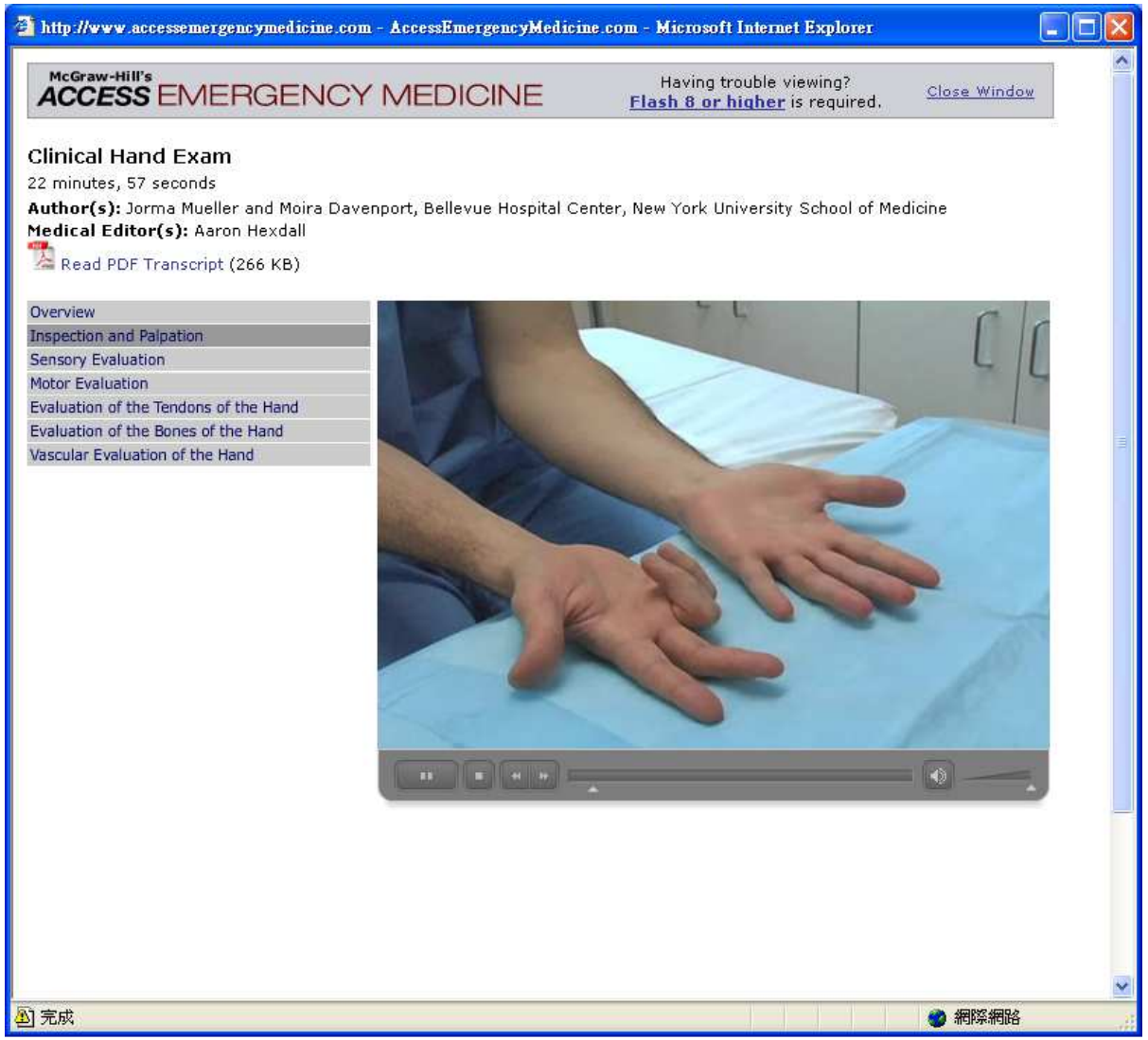
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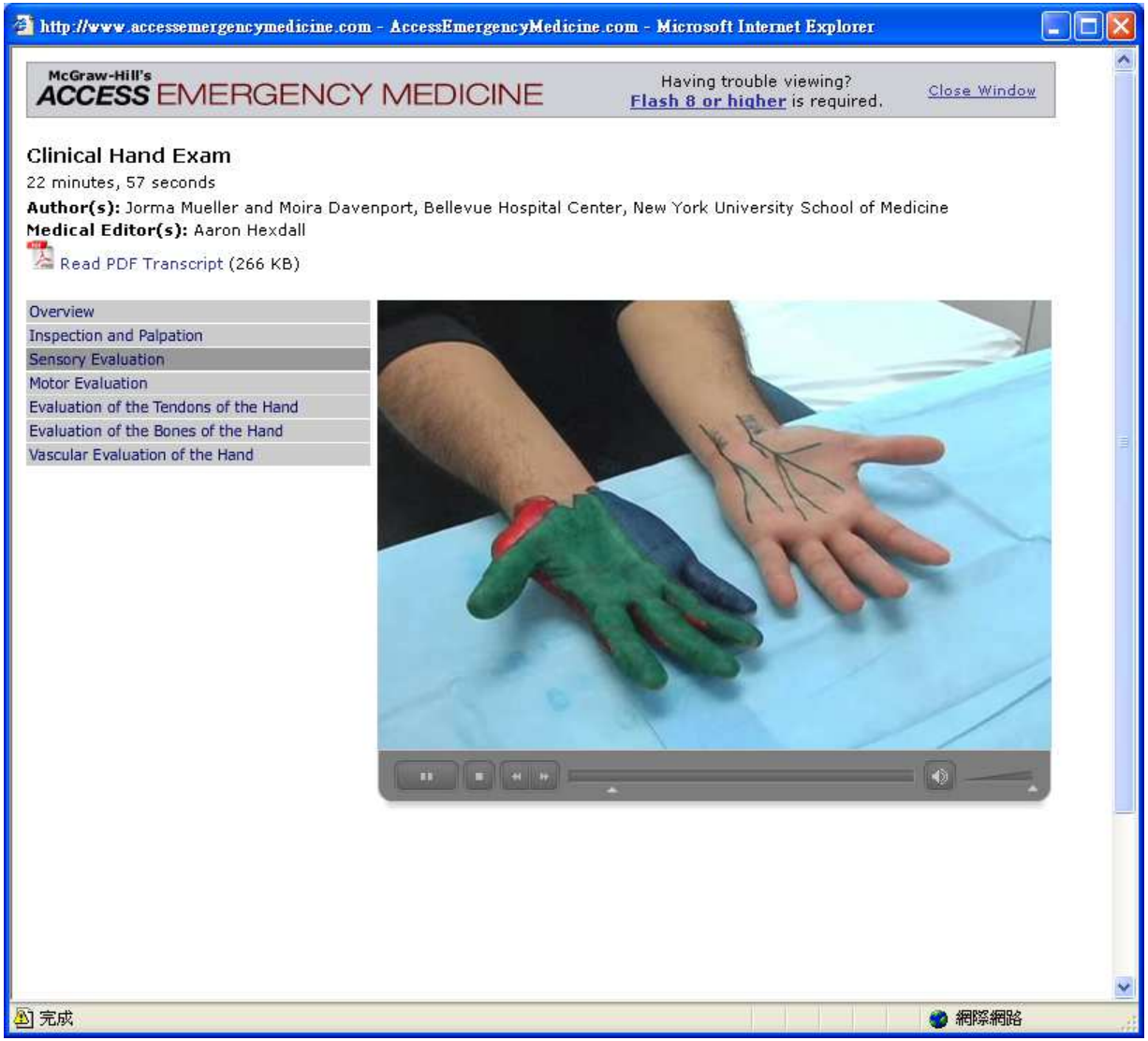
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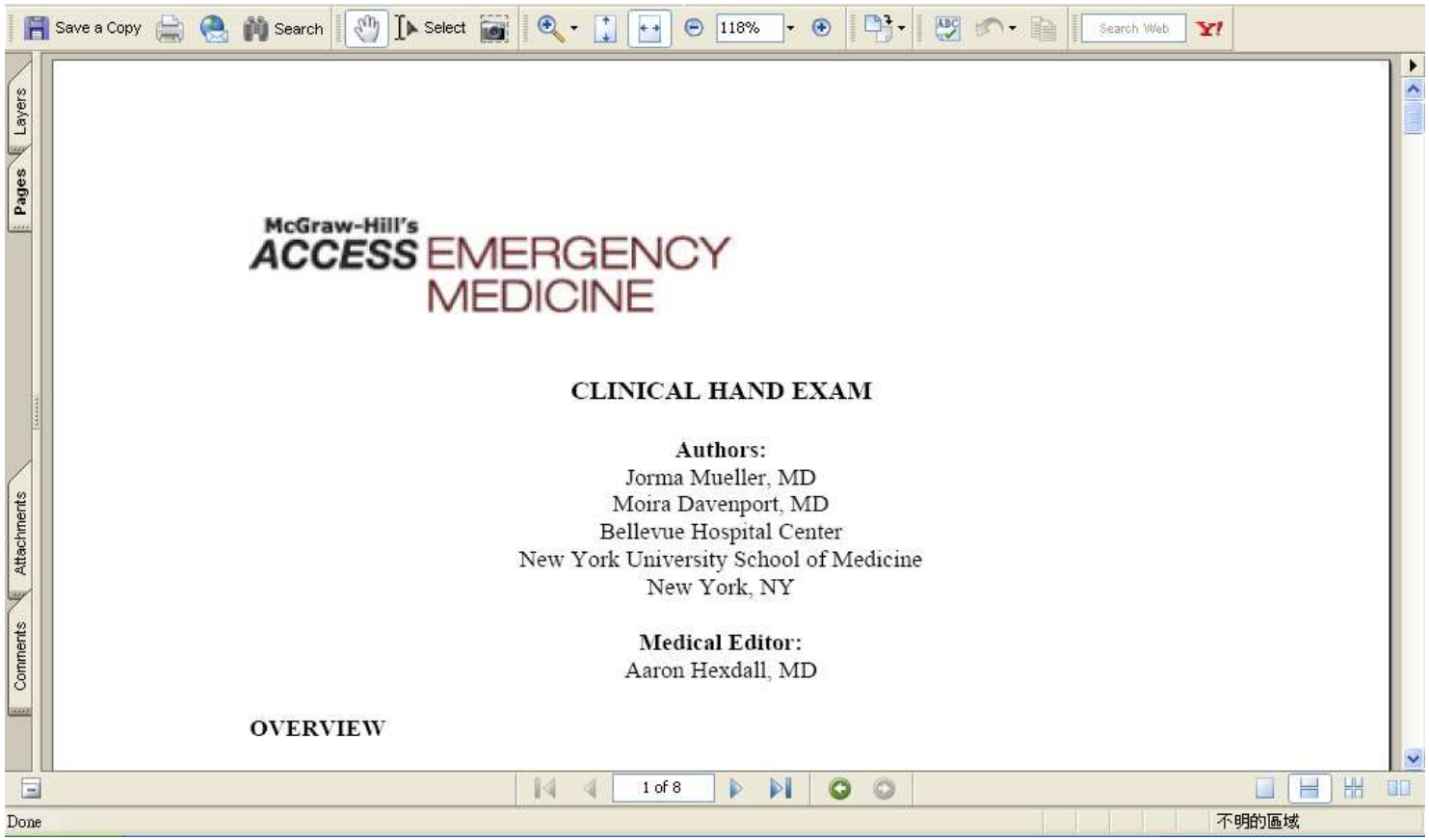
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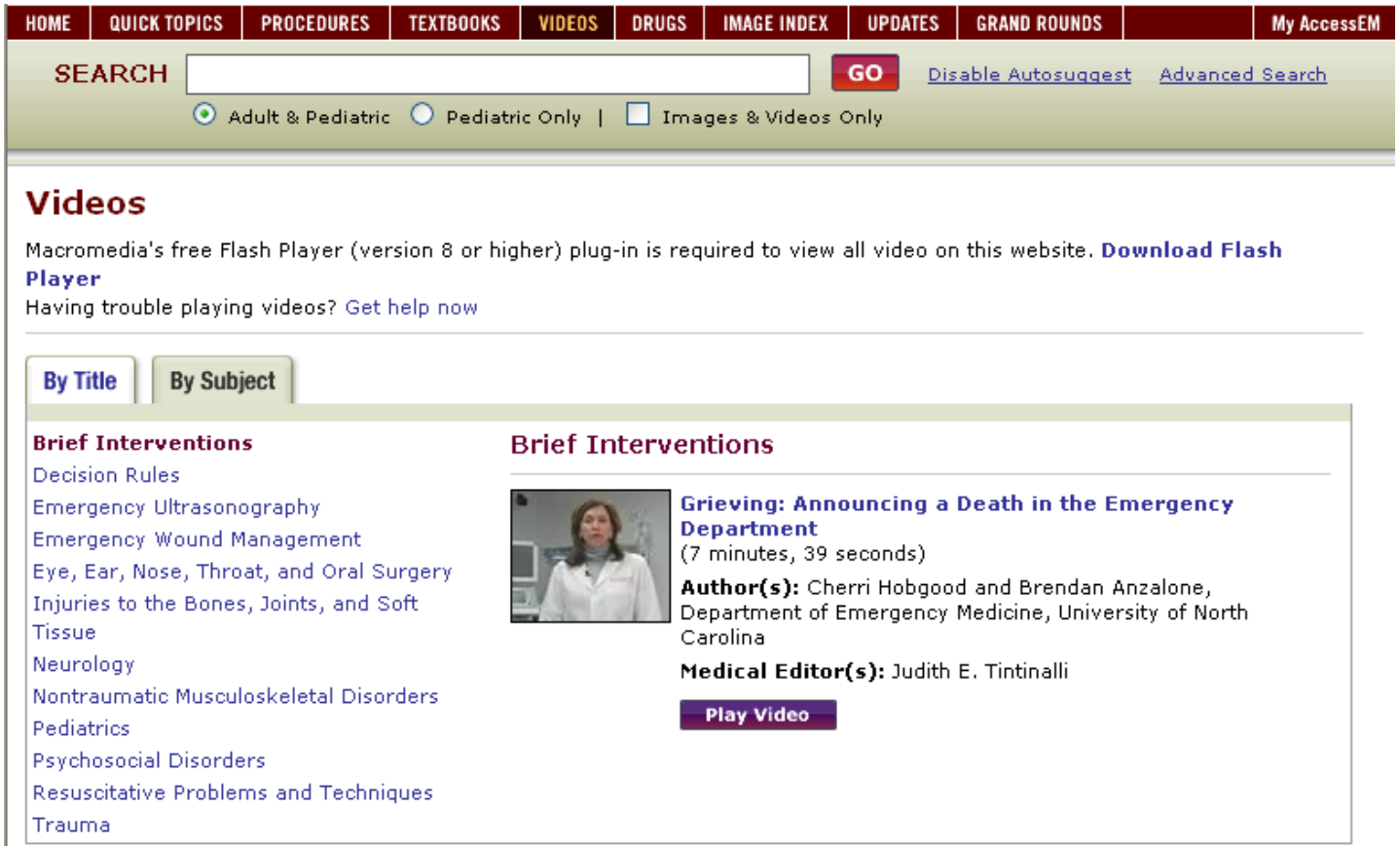
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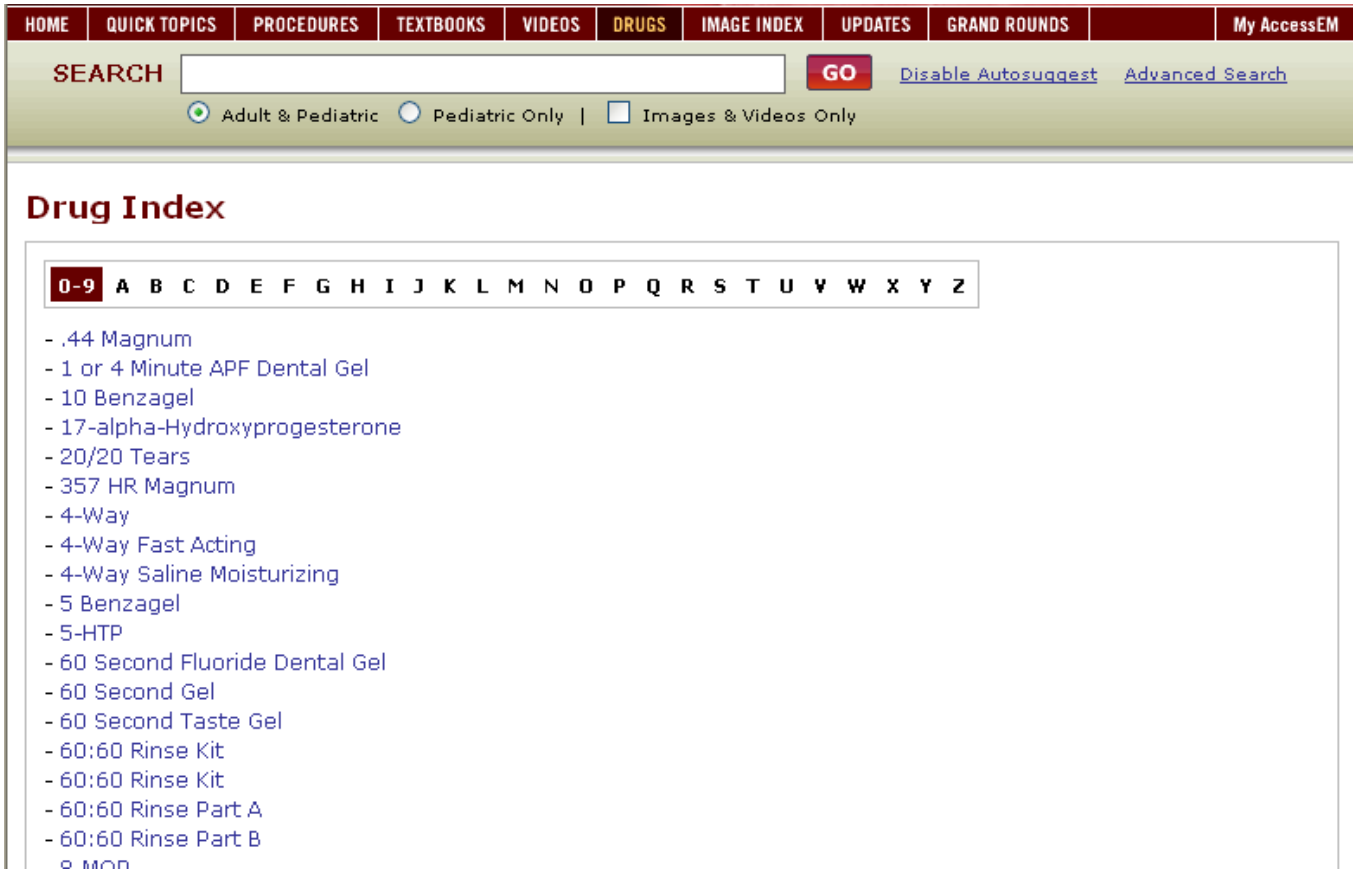
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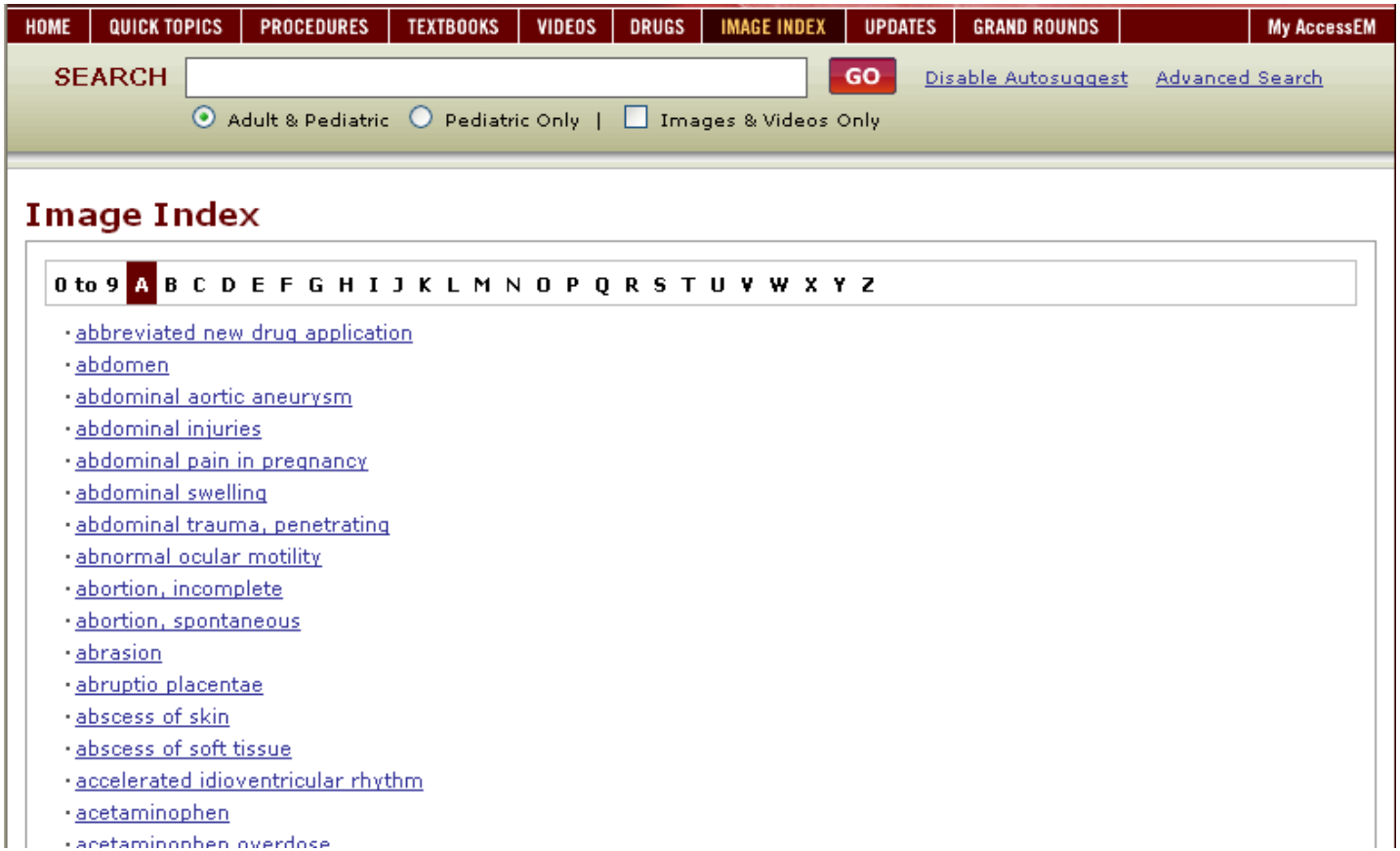
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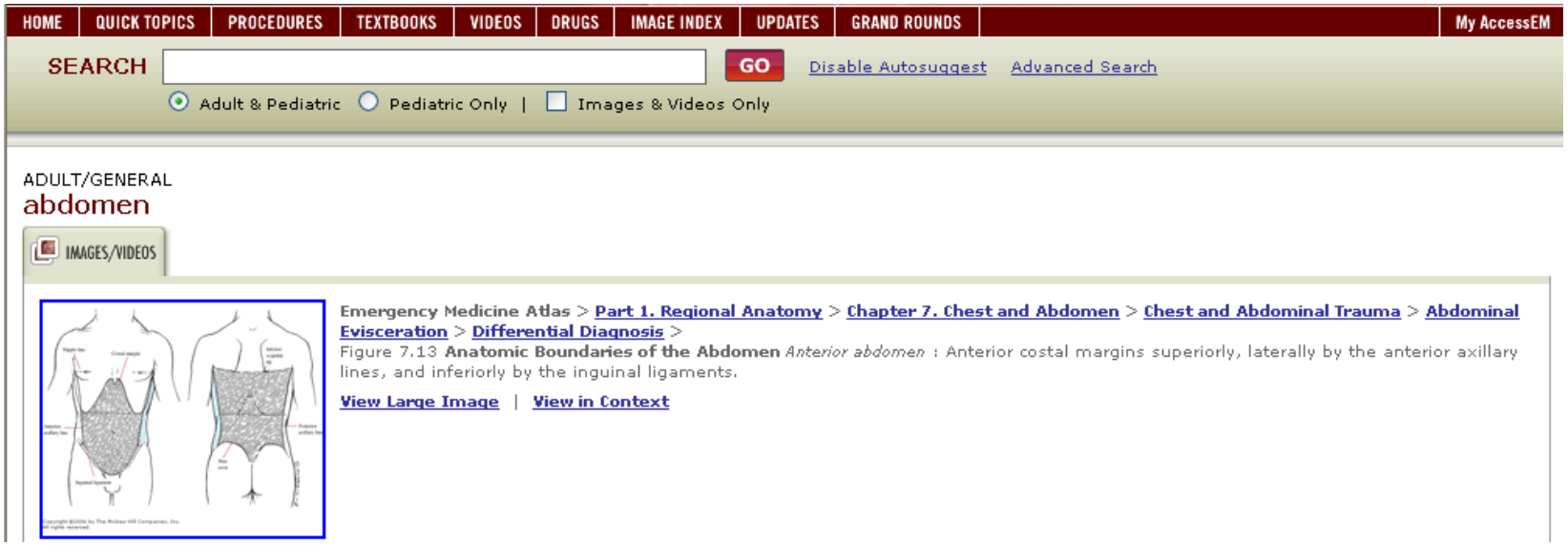
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Figure 7.13 Anatomic Boundaries of the Abdomen Anterior abdomen : Anterior costal margins superiorly, laterally by the anterior axillary lines, and inferiorly by the inguinal ligaments.
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Update

4/10/2008: EMERGENCY MEDICINE: ASYMPTOMATIC HYPERTENSION IN THE EMERGENCY DEPARTMENT: FIRST, DO NO HARM

Matthew R. Lewin
Assistant Clinical Professor of Medicine and Director of Research, Division of Emergency Medicine, University of California, San Francisco School of Medicine
Rina Shah, Subhani Dawood
Research Fellows, Division of Emergency Medicine, University of California, San Francisco School of Medicine

Related To: Chapter 57. Hypertension

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Overview

Hypertension affects approximately 50 million people in the United States and accounts for 35 million office visits, making it the most common primary diagnosis. The health risks caused by prolonged untreated hypertension are serious.[1] In individuals aged 40-70 years, each increment of 20 mm Hg in systolic pressure or 10 mm Hg in diastolic pressure doubles the risk of cardiovascular events.[2] (See Table 1.) How to advise patients presenting to the emergency department (ED) with an incidental finding of asymptomatic hypertension is an issue faced by every practicing emergency physician every day—even if they are not consciously aware of it. And, in addition, because many of these patients will not seek primary health care follow-up due to socioeconomic barriers.[3-5] Based on these concerns, this clinical policy was developed to provide an analysis of the literature about asymptomatic hypertension in the ED.

The critical questions asked by the committee were (a) whether the ED blood pressure readings are accurate and reliable for screening asymptomatic patients for hypertension? (b) How many blood pressure readings should be obtained for screening purposes? (c) Do asymptomatic patients with elevated blood pressure benefit from lowering of their blood pressure?

Grand Rounds

Grand Rounds

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4/10/07

Head CT Scan Interpretation: An Organized Approach to Seeing Inside the Head

by Lawrence B. Stack
Associate Professor of Emergency Medicine, Vanderbilt University

Start the lecture **(22 minutes, 40 seconds)**
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About this lecture:
This Grand Rounds summarizes the 5-step approach to accurately interpret a Head CT scan. Representative scans for specific diagnoses such as epidural hematoma, subdural hematoma, cerebral contusion, and intraparenchymal hemorrhage are demonstrated.

All CT scans within the slides can be enlarged by clicking on them. Larger images will open in a separate window.

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Lecture related to:
Knoop: Atlas of Emergency Medicine, 2nd Edition, Chapter 1: Head and Facial Trauma

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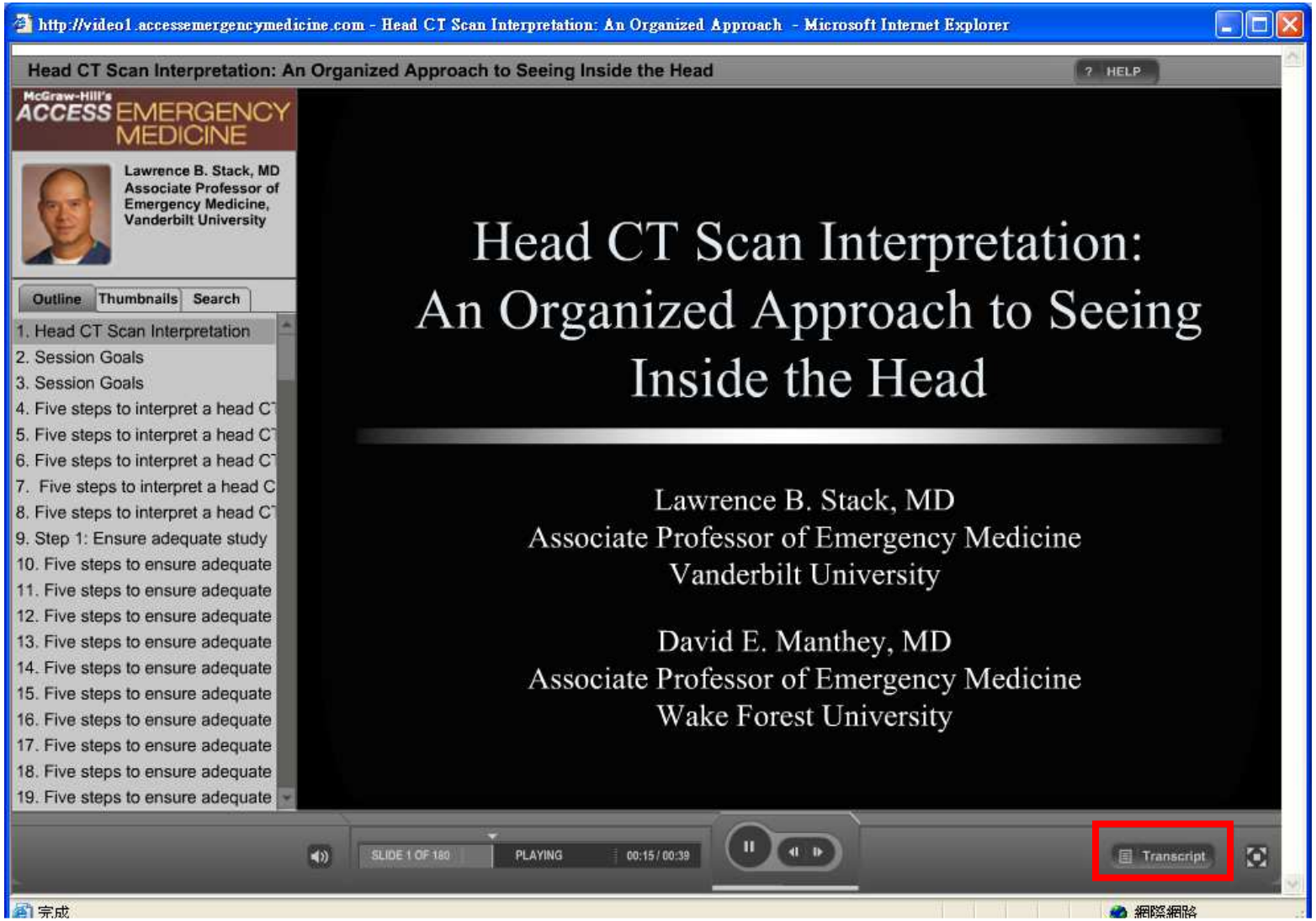
Grand Rounds



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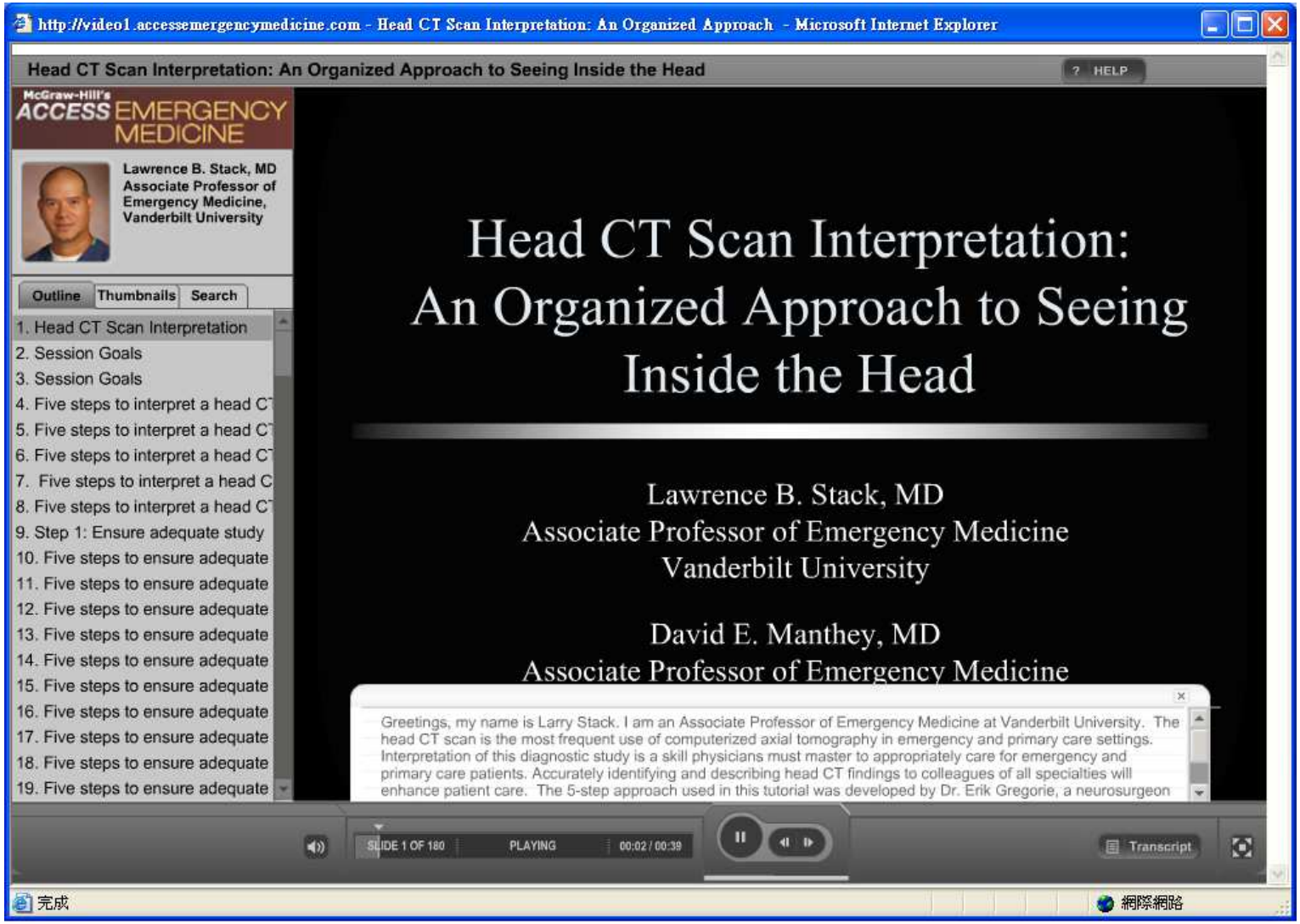

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Head CT Scan Interpretation: An Organized Approach to Seeing Inside the Head

by Lawrence B. Stack, MD
Associate Professor of Emergency Medicine, Vanderbilt University

Lecture related to:
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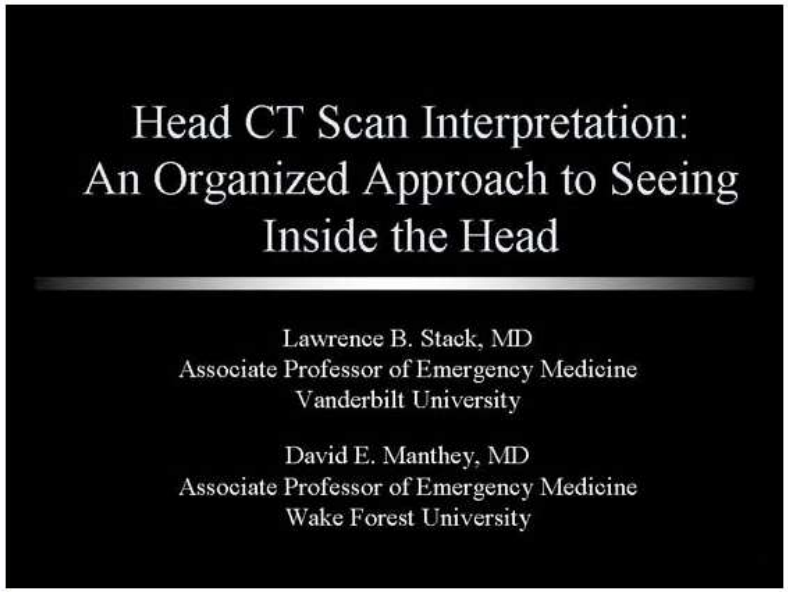
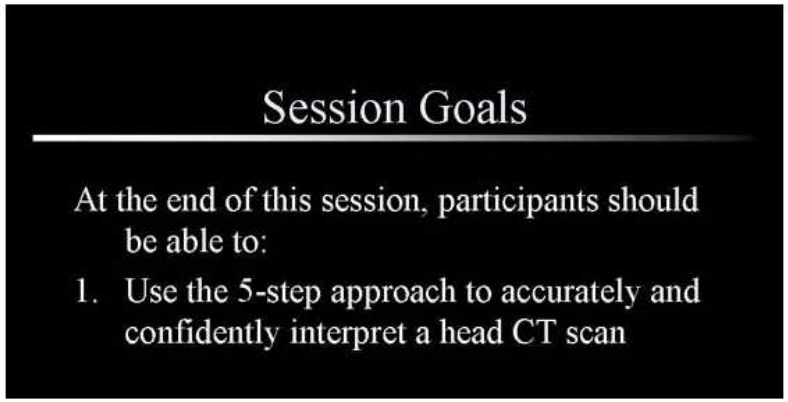
Slide 1: Introduction



Greetings, my name is Larry Stack. I am an Associate Professor of Emergency Medicine at Vanderbilt University. The head CT scan is the most frequent use of computerized axial tomography in emergency and primary care settings. Interpretation of this diagnostic study is a skill physicians must master to appropriately care for emergency and primary care patients. Accurately identifying and describing head CT findings to colleagues of all specialties will enhance patient care.
The 5-step approach used in this tutorial was developed by Dr. Erik Gregorie, a neurosurgeon from Brooke Army Medical Center in San Antonio, Texas and refined by David Manthey, an emergency medicine colleague from Wake Forest University. It is a simple, easy to remember method to accurately interpret a head CT scan.

Slide 2: Session Goals



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Grand Rounds

Chapter 1. Head and Facial Trauma

David W. Munter, Timothy D. McGuirk

BASILAR SKULL FRACTURE

Associated Clinical Features

The skull base comprises the floors of the anterior, middle, and posterior cranial fossae. Trauma resulting in fractures to this basilar area typically does not have localizing symptoms. Plain skull radiographs are poor in identifying these fractures. Indirect signs of the injury may include visible evidence of bleeding from the fracture into surrounding soft tissue, such as a Battle's sign (Figs. 1.1, 1.2) or "raccoon eyes" (Fig. 1.3). Bleeding into other structures—including hemotympanum (Fig. 1.4) or blood in the sphenoid sinus seen as an air-fluid level—may also be seen. Cerebrospinal fluid (CSF) leaks may also be evident and noted as clear or pink rhinorrhea. If CSF is present, a dextrose stick test may be positive. The fluid can be placed on filter paper and a "halo" or double ring may be seen (Fig. 1.5).

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Battle's Sign Ecchymosis in the postauricular area develops when the fracture line communicates with the mastoid air cells, resulting in blood accumulating in the cutaneous tissue. This patient had sustained injuries several days prior to presentation. (Courtesy of Frank Birinyi, MD.)

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hypertension, as cause of headache

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Hypertension

Christopher J. Denny, Michael J. Schull

HEADACHE

HYPERTENSION

See also Chap. 57. Hypertension may cause headaches, with higher diastolic pressures generally associated with more severe headaches. Physicians should be cautious prior to making this diagnosis, however, because hypertension also may occur as a sign of other secondary headache conditions (e.g., stroke, pheochromocytoma, or preeclampsia) or simply may be secondary to the pain and anxiety associated with a primary headache syndrome.[3] When other secondary causes of headache, including hypertensive emergency, have been excluded, reduction of the blood pressure should result in improvement or resolution of the headache. While some consider isolated headache associated with hypertension as evidence of possible end-organ involvement, most such patients can be discharged following complete resolution of symptoms and blood pressure reduction if follow-up in the next 24 to 48 h can be arranged.

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hypertension

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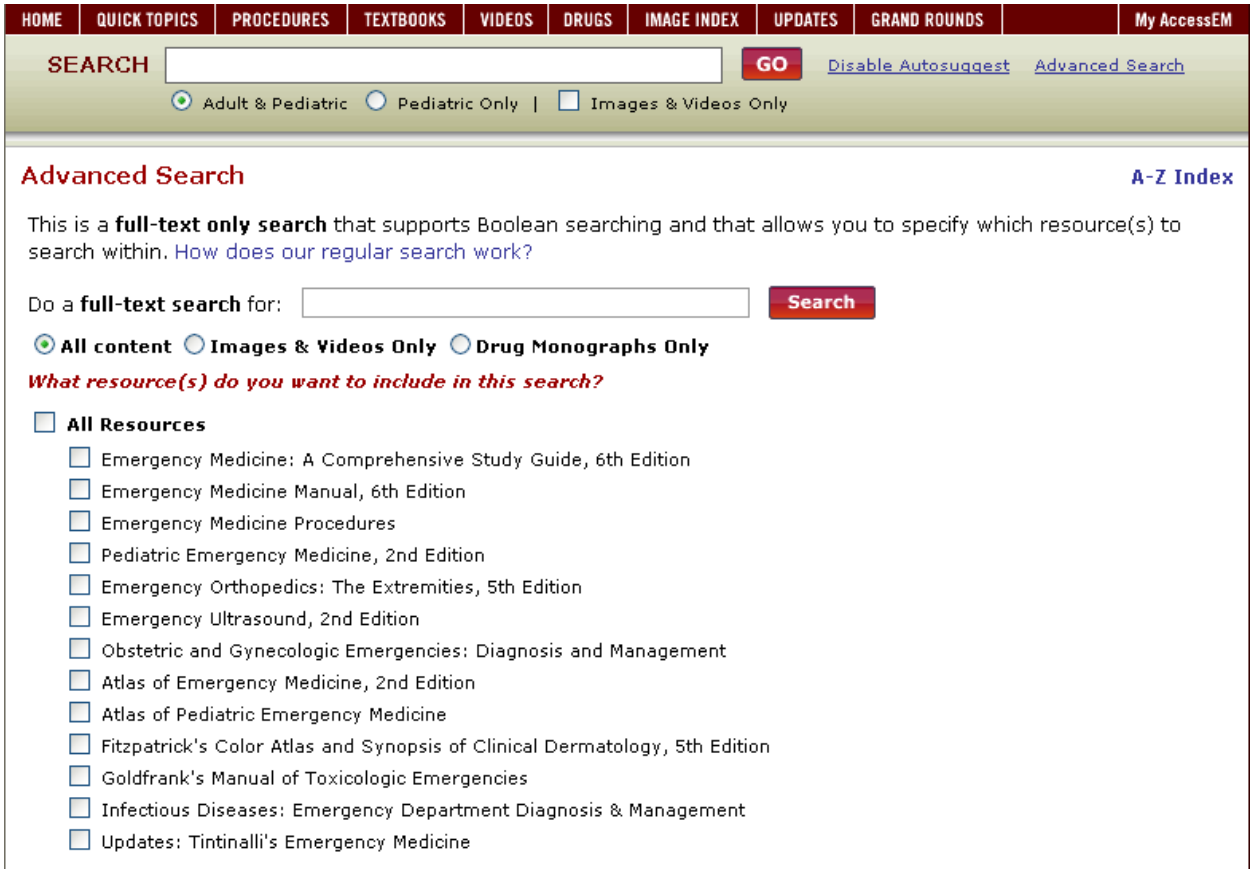

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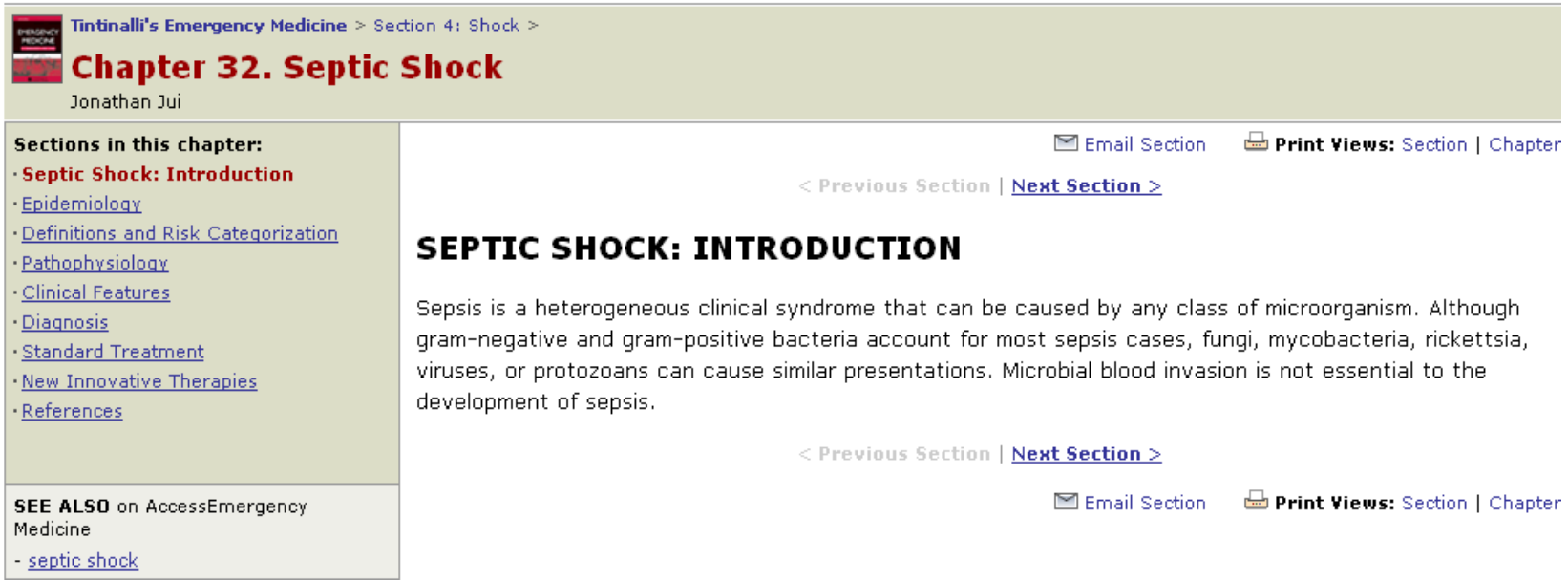

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Chapter 32. Septic Shock

Jonathan Jui

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- Definitions and Risk Categorization
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- Clinical Features
- Diagnosis
- Standard Treatment
- New Innovative Therapies
- References

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- septic shock

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SEPTIC SHOCK: INTRODUCTION

Sepsis is a heterogeneous clinical syndrome that can be caused by any class of microorganism. Although gram-negative and gram-positive bacteria account for most sepsis cases, fungi, mycobacteria, rickettsia, viruses, or protozoans can cause similar presentations. Microbial blood invasion is not essential to the development of sepsis.

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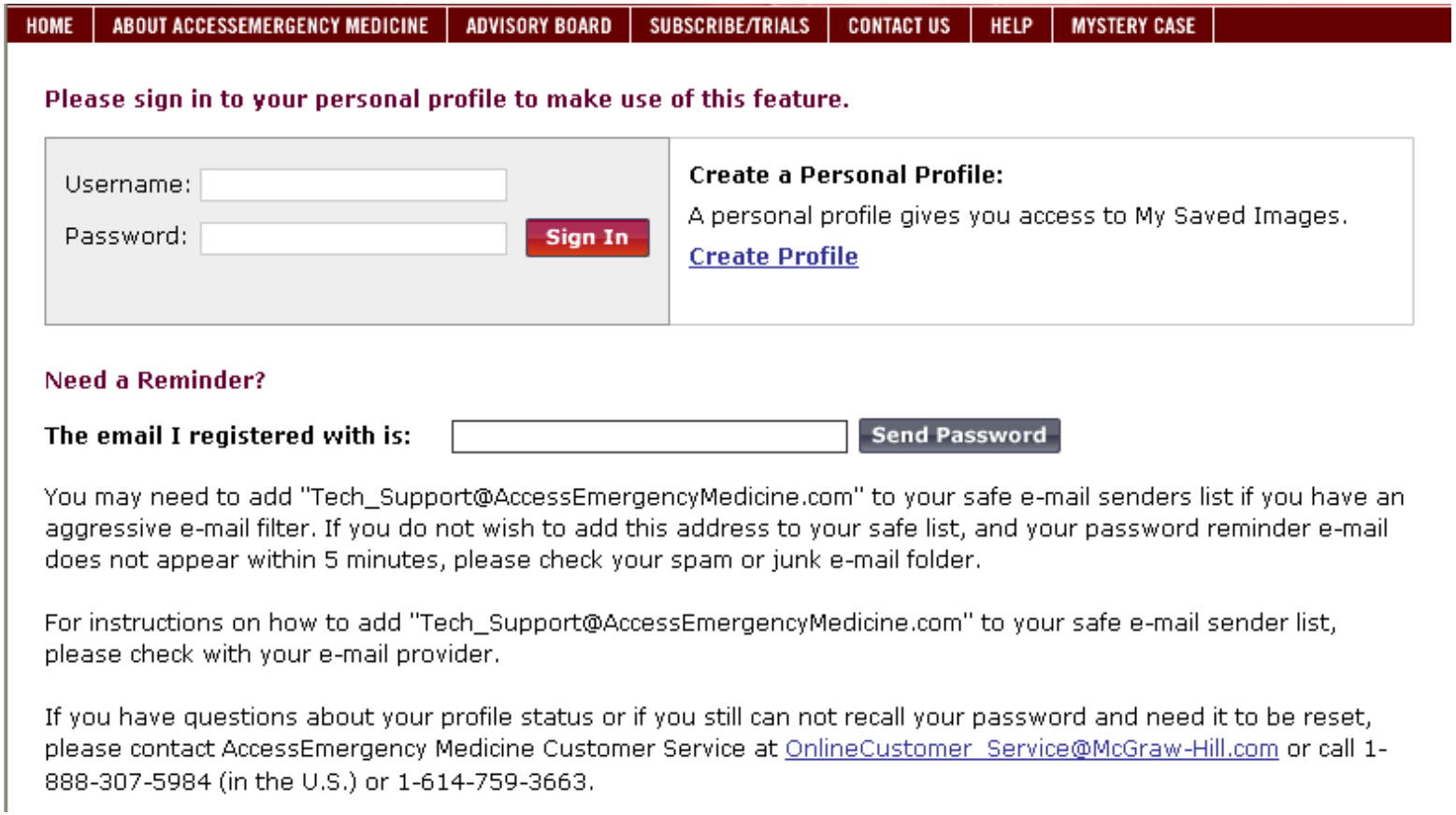

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