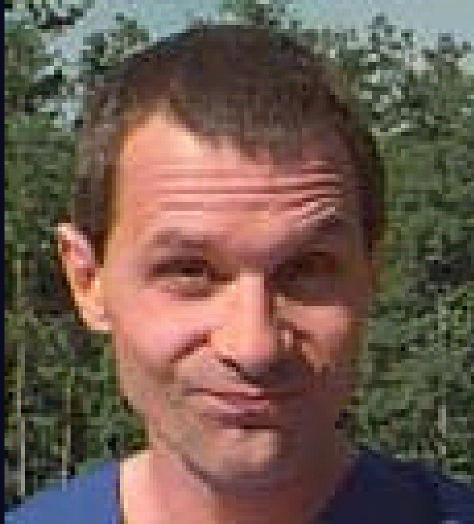

Fowler's

"Truths of Emergency Medicine"

Raymond L. Fowler, M.D., FACEP

Associate Professor of Emergency Medicine
The University of Texas Southwestern

Chief of EMS Operations
The Dallas Metropolitan BioTel System

Co-Chief in the Section on
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Attending Faculty
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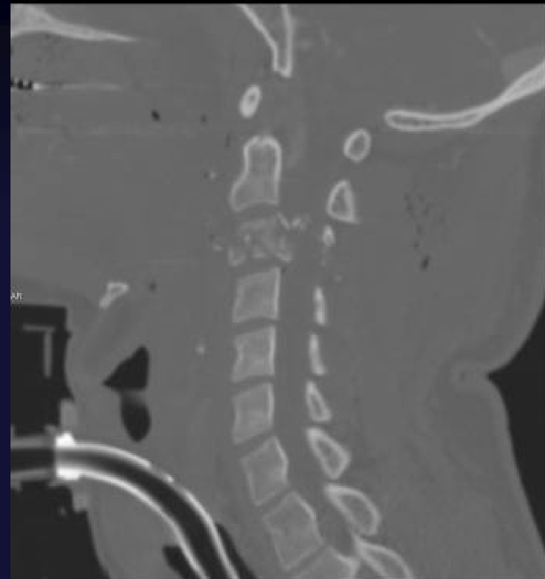
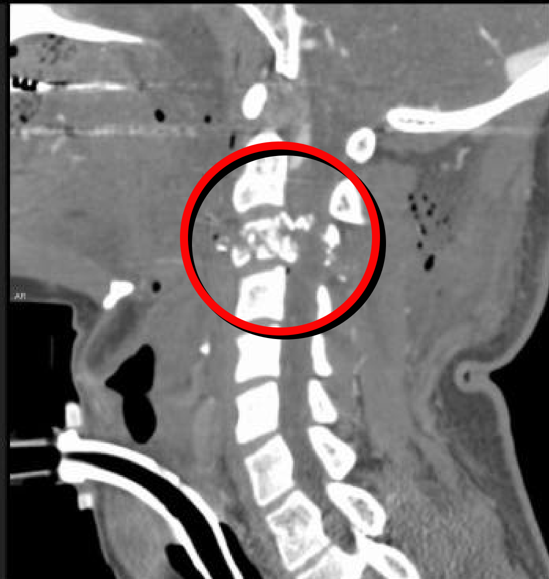
www.rayfowler.com

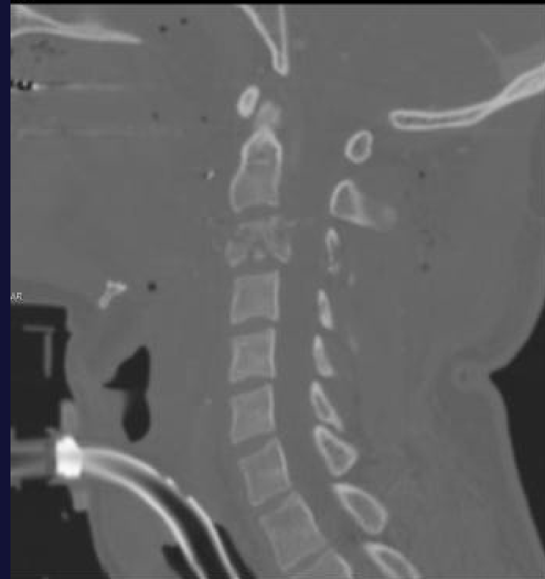
1.We have two responsibilities in emergency medicine:

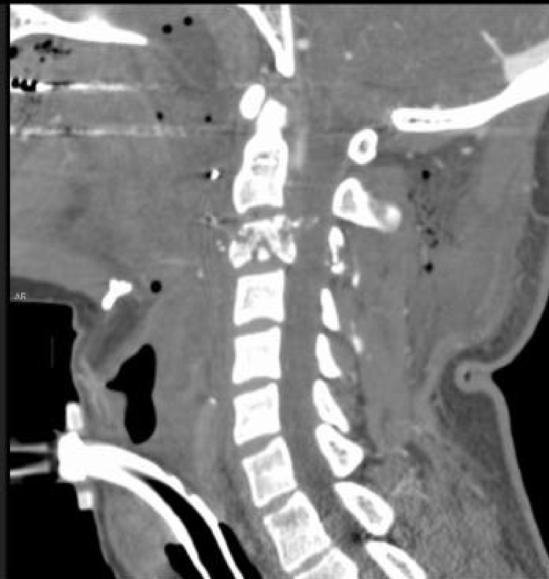
(1)Is there an emergency present? Corollary, is it a life-threatening emergency, and

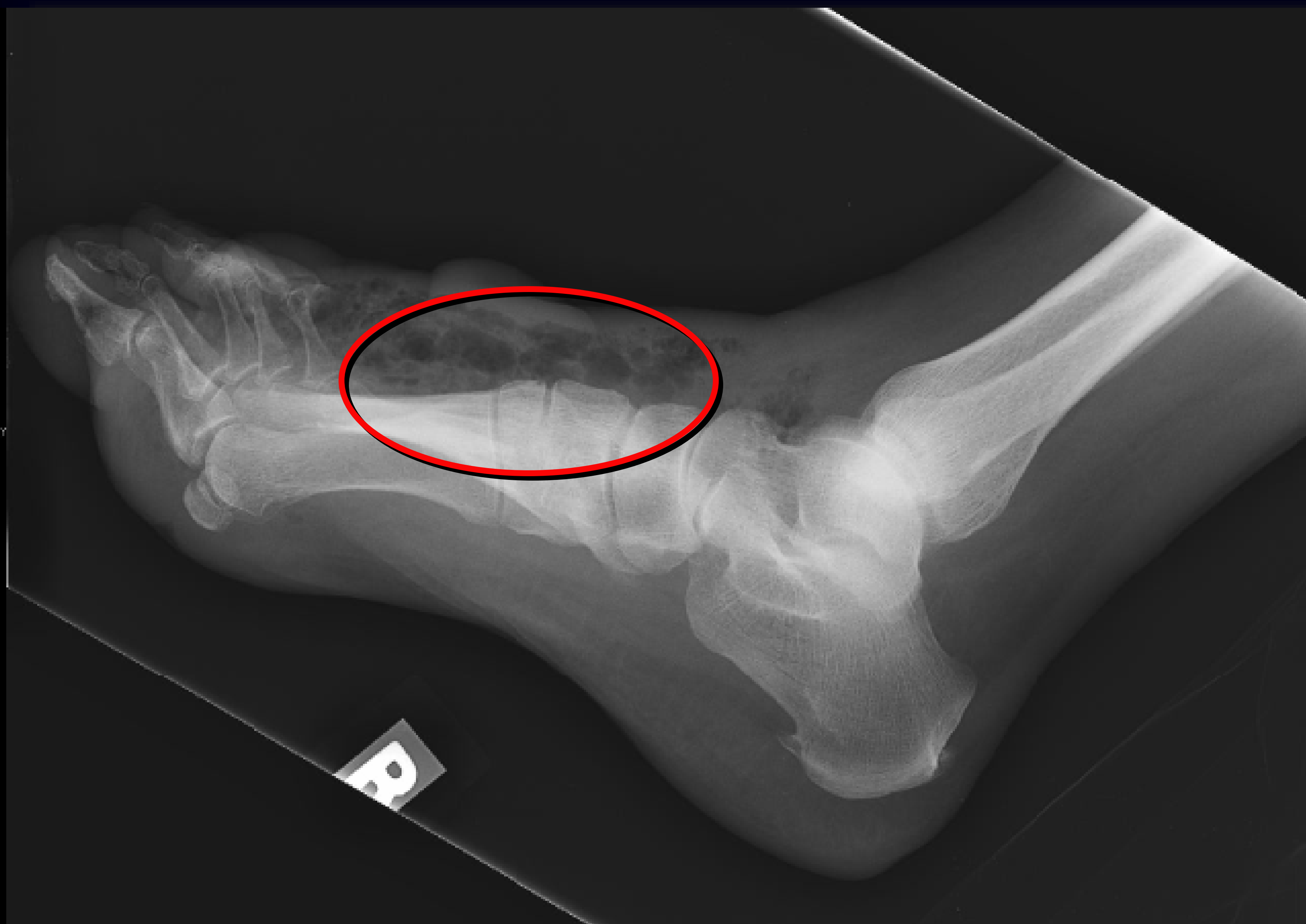
(2) What is the best diagnosis you can make?



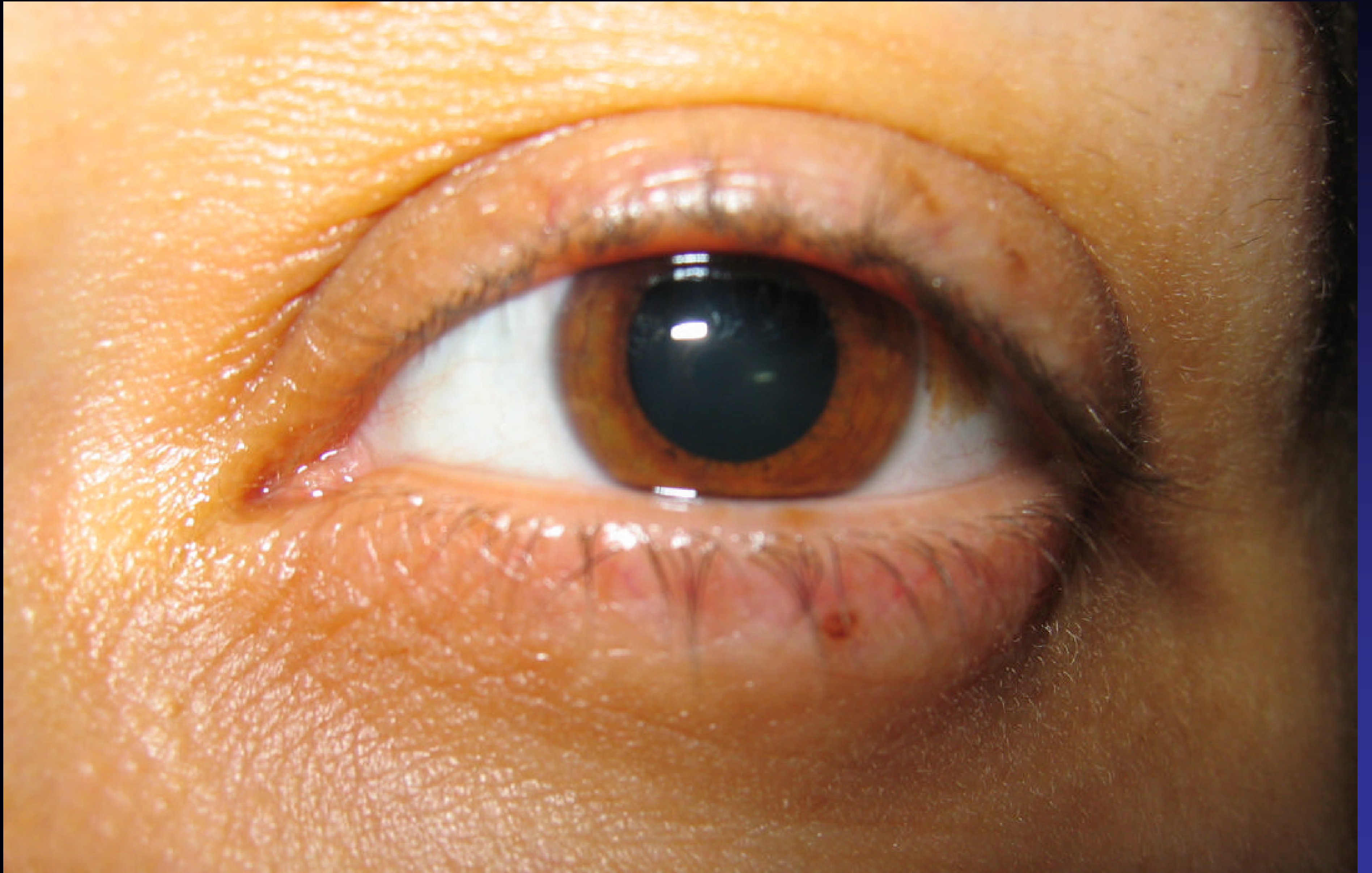




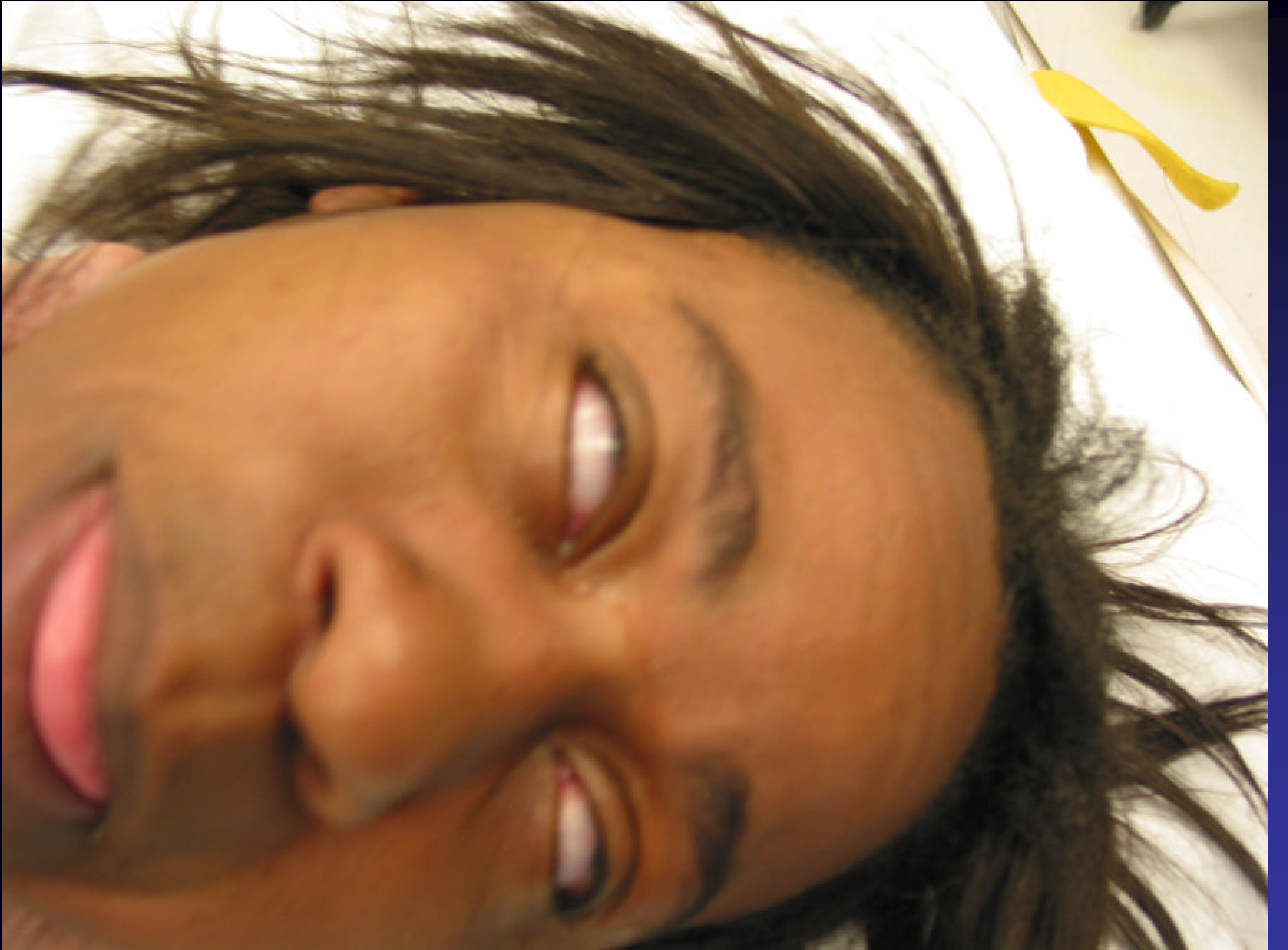




2. Find out what the REAL emergency is

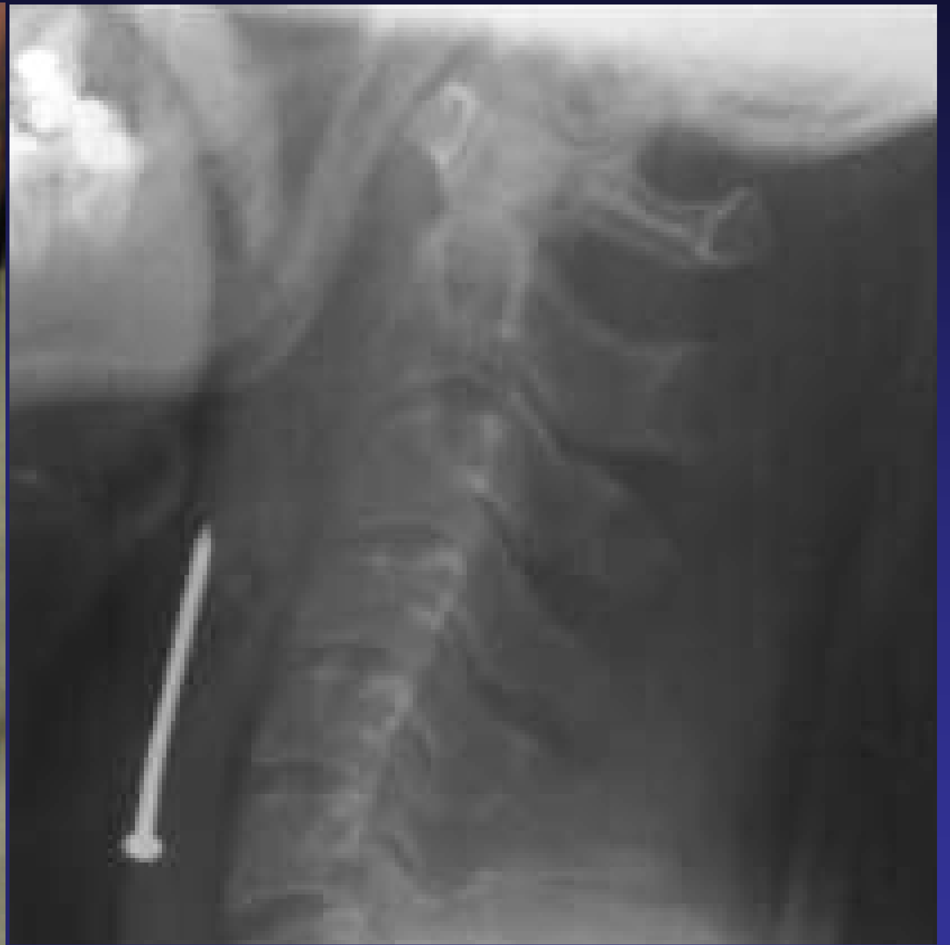


3. Be a fierce advocate for the needs of your patient



4. A patient with a painful condition HAS a painful condition until proven otherwise…

…and failure to treat pain appropriately is mal-treatment



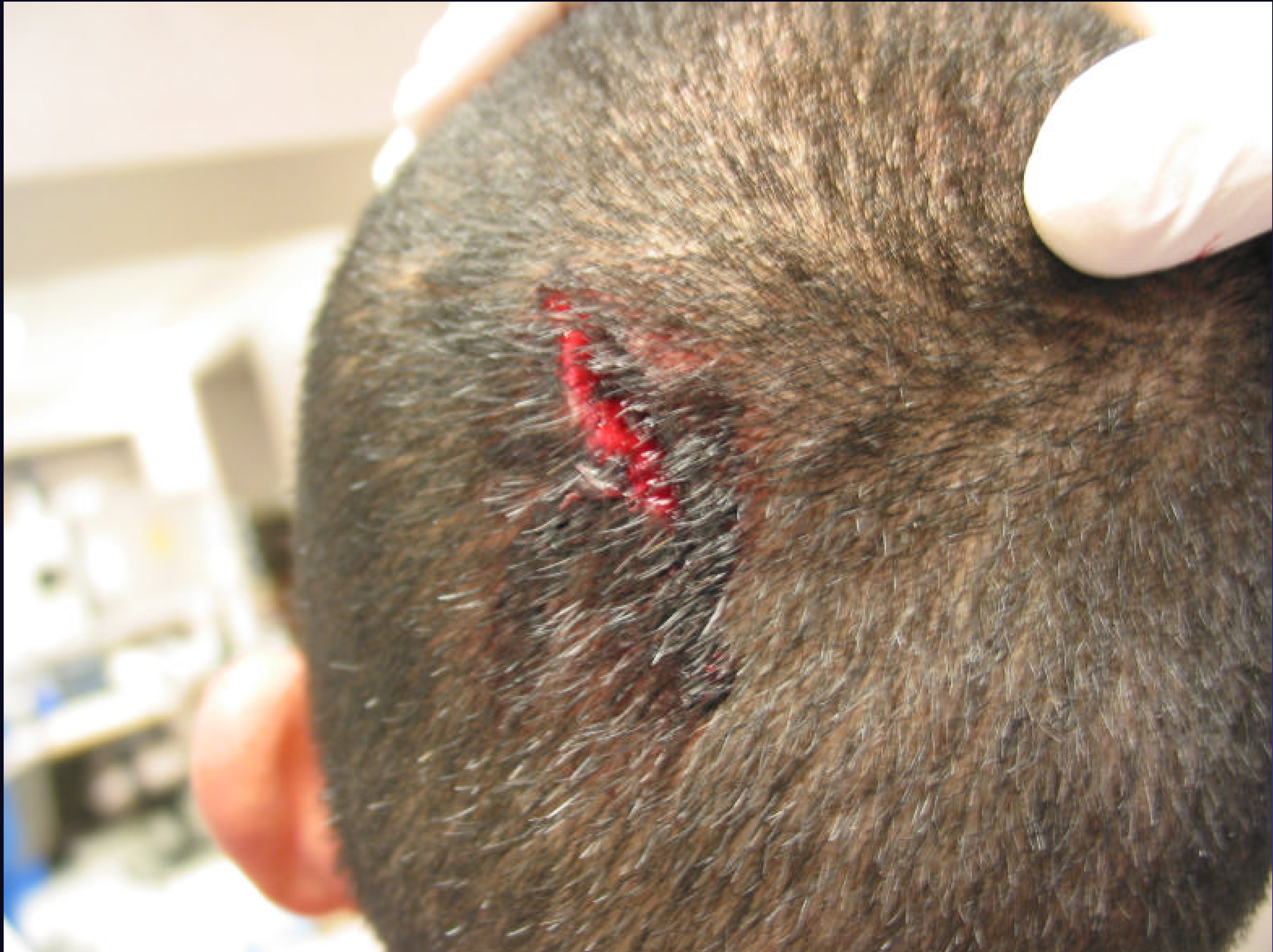
5. When in doubt, take more history...

History Taking:

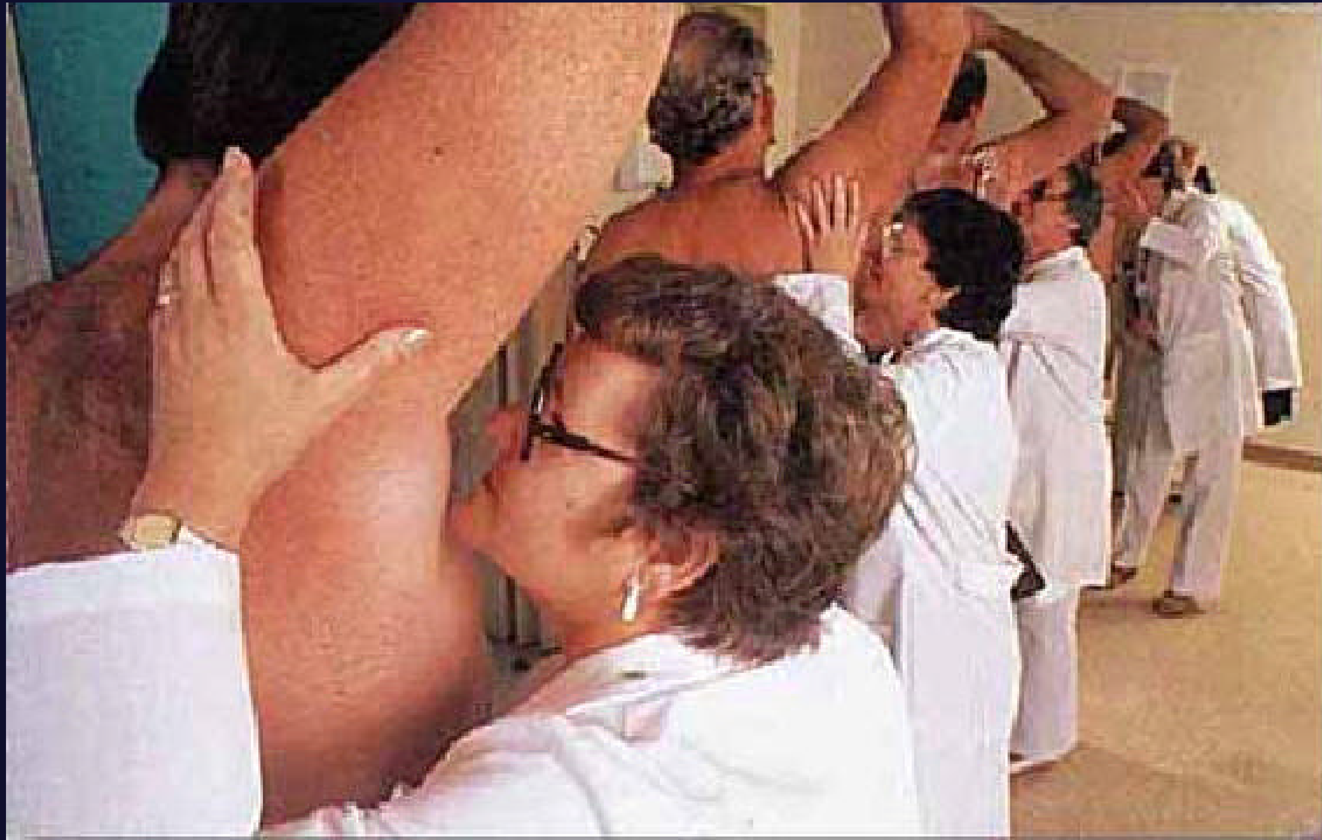
This seems to be a
"lost black art" for
so many medical providers

What happened?
When?
LOC?
Major system symptoms?
Co-morbid conditions?

Above all: RISK???

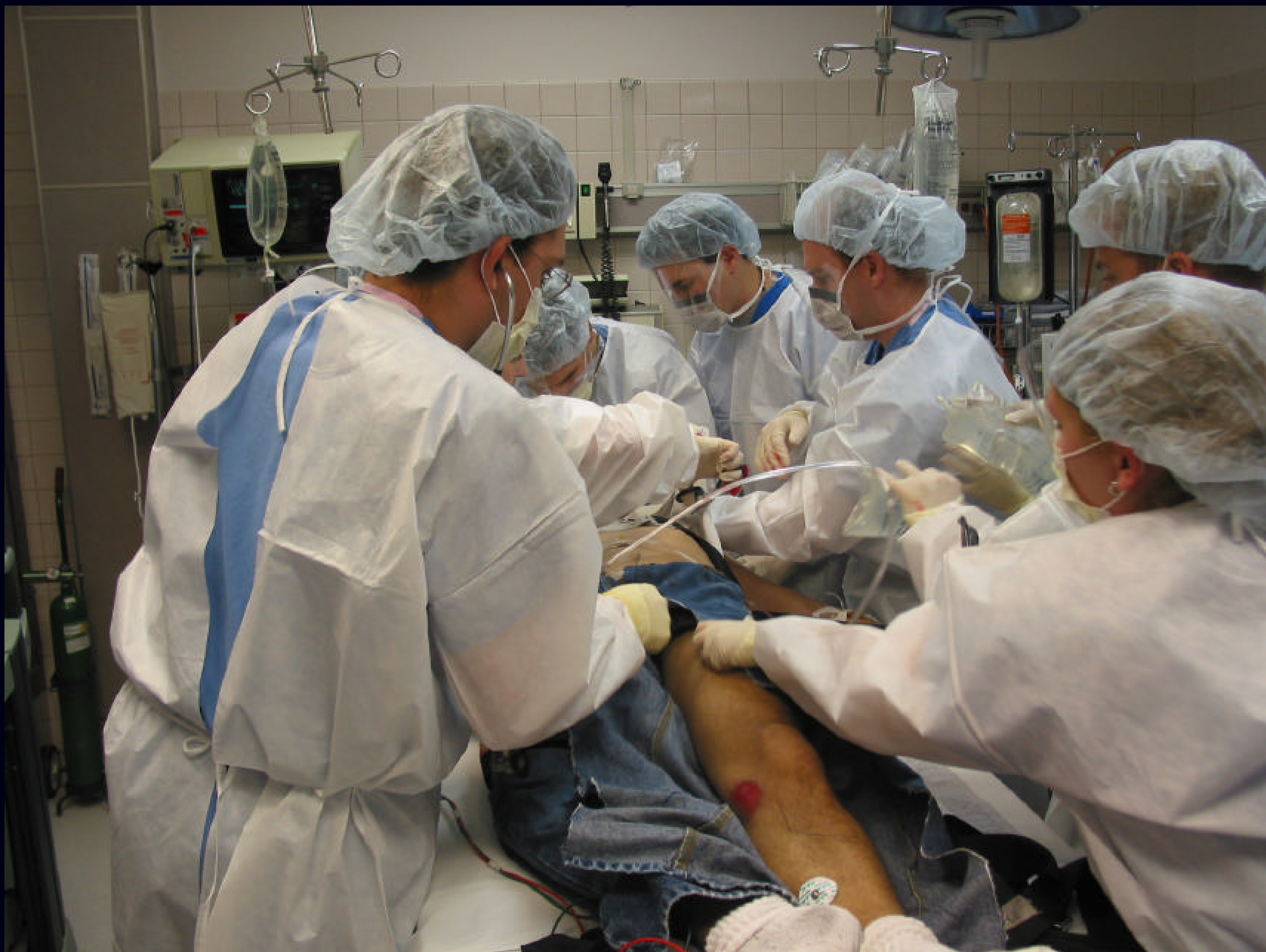


We are, after all, a specialty:



The difference between
a "specialist" and a
"generalist" is in the
RIGOR of the application
of a differential diagnosis

6. DEVELOP a physical exam that you trust, and ALWAYS do it

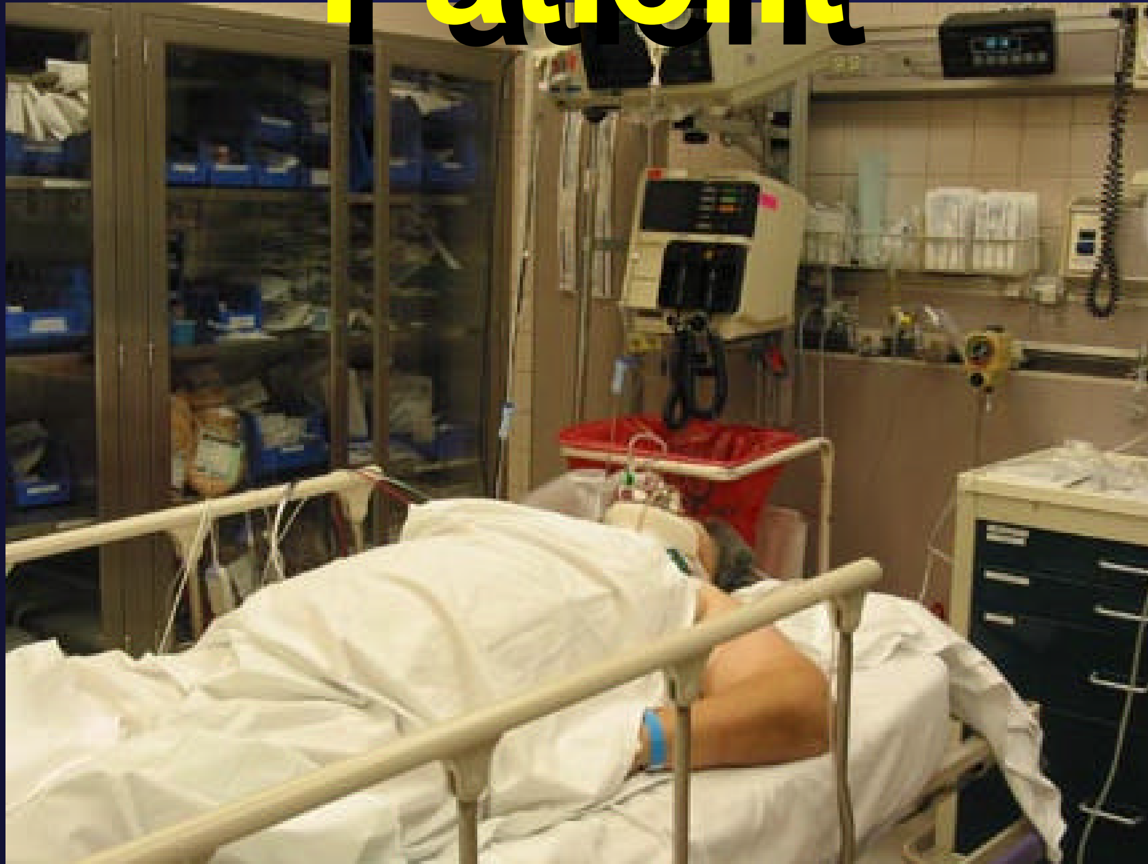


Assessment skills are NOT genetically acquired

The “art” of medicine is missing from so many practitioners…

…are they not looking, or have they lost interest?

Approaching the Patient

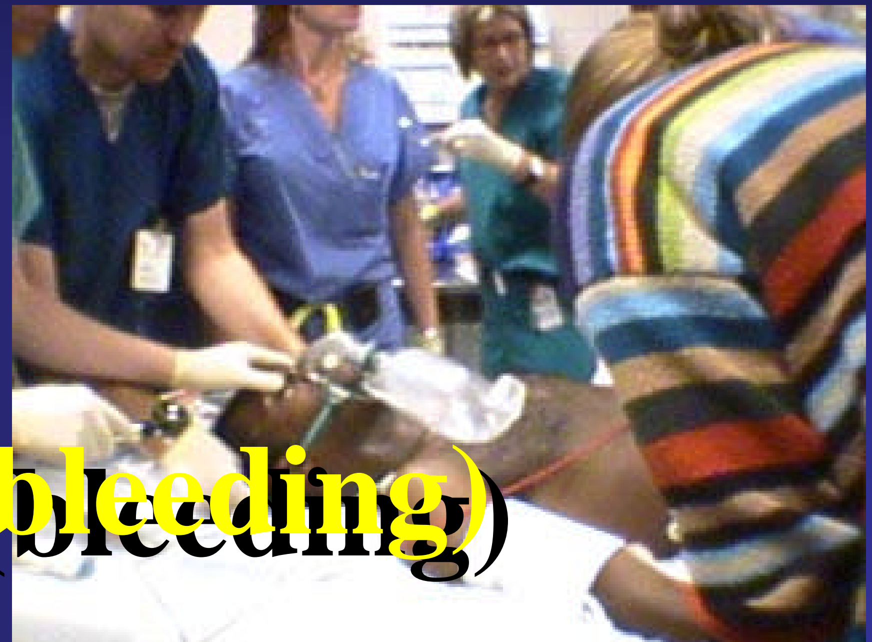


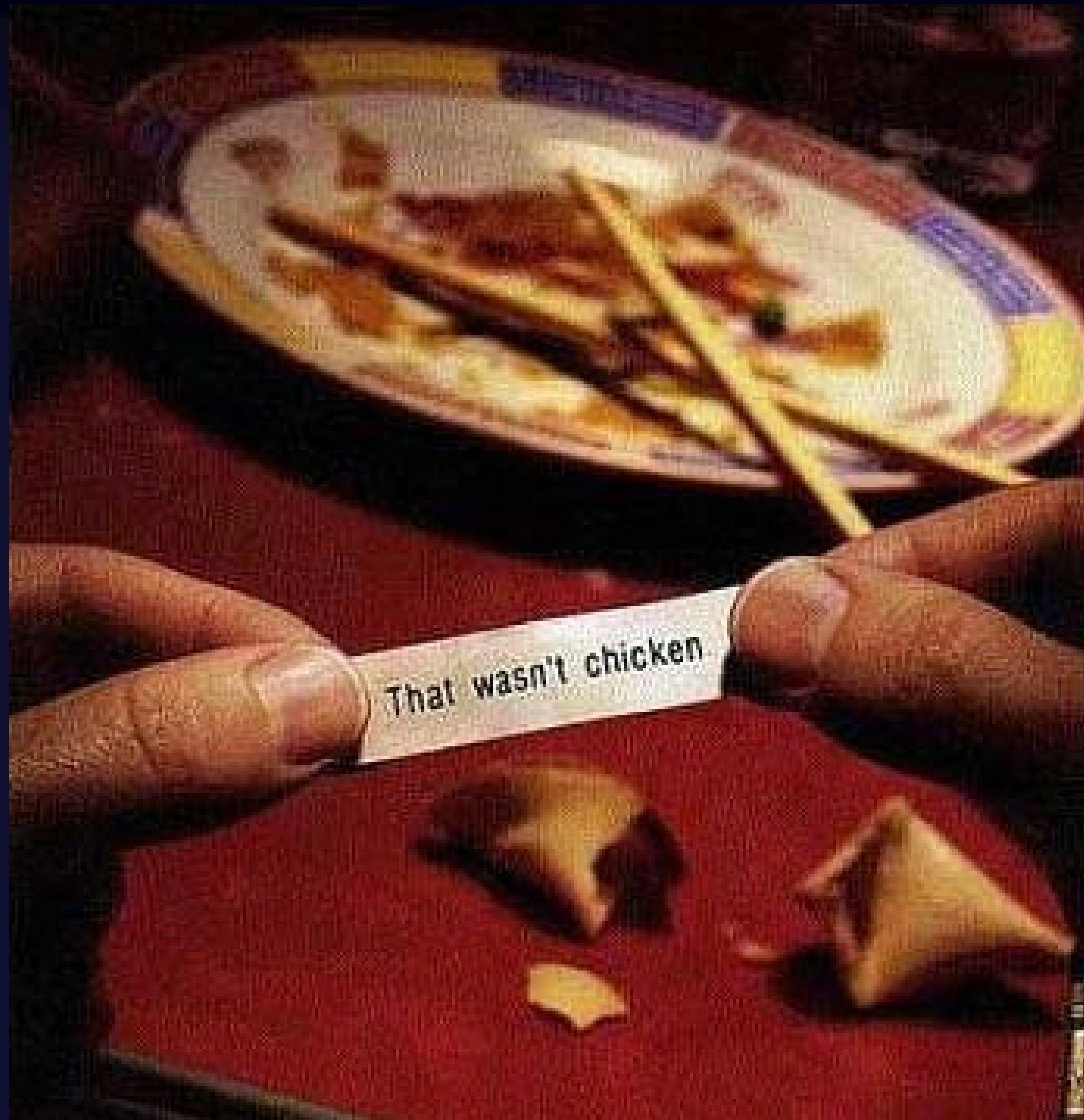
"See what you see!"

"People look, but they don't see"

…A. Fowler, Jr.

Alertness?
Level of distress?
Noises?
Respirations?
The pulse rate?
Skin?
Obvious things (bleeding)




That wasn't chicken

Part of excellence is performing superior medical histories and physical exams

Elements of our primary and secondary surveys are often jumbled or forgotten

Primary Survey

LOC/Airway/Cspine
Respiratory Rate and Labor
Pulses, Neck and Wrist
Skin CMT/CRT
Neck appearance, NVD, Trachea
Chest appearance
Breath sounds present and equal
Brief exam of abd, pelvis, LE, UE, Back

Secondary Survey

Head
Neck
Chest/CV
Abd
Pelvis
Extr
Back

Third Survey

LOC

Airway

Breathing: R & Q

Circulation: Pulse, BP, CMT/CRT

…and any other pertinent positive or negative identified in the primary or secondary

Blood pressure =

(Cardiac output) x
(Volume) x
(Peripheral resistance)

Signs of Shock

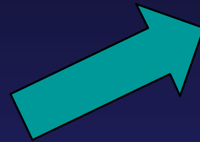
Early
(compensated)

Weak, thirsty, lightheaded
Pale, then sweaty
Tachycardia
Tachypnea
Diminished urinary output

Late
(decompensated)

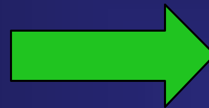
Hypotension
Altered LOC
Cardiac arrest
Death

Shock



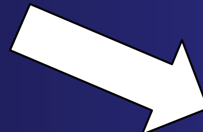
Cardiogenic

- Rapid pulse
- Distended neck veins
- Cyanosis



Volume Loss

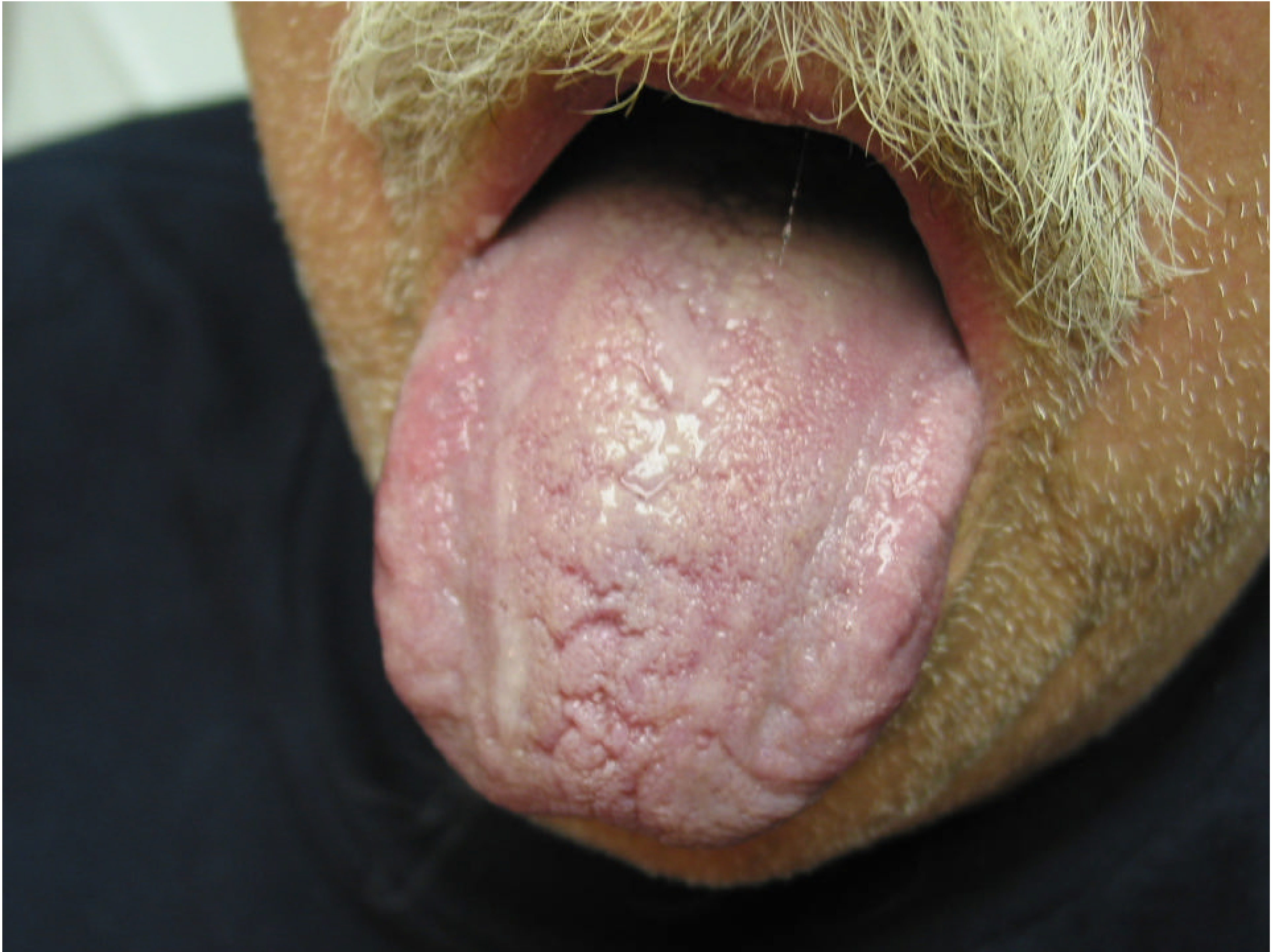
- Rapid pulse
- Flat neck veins
- Pale



Vasodilatory

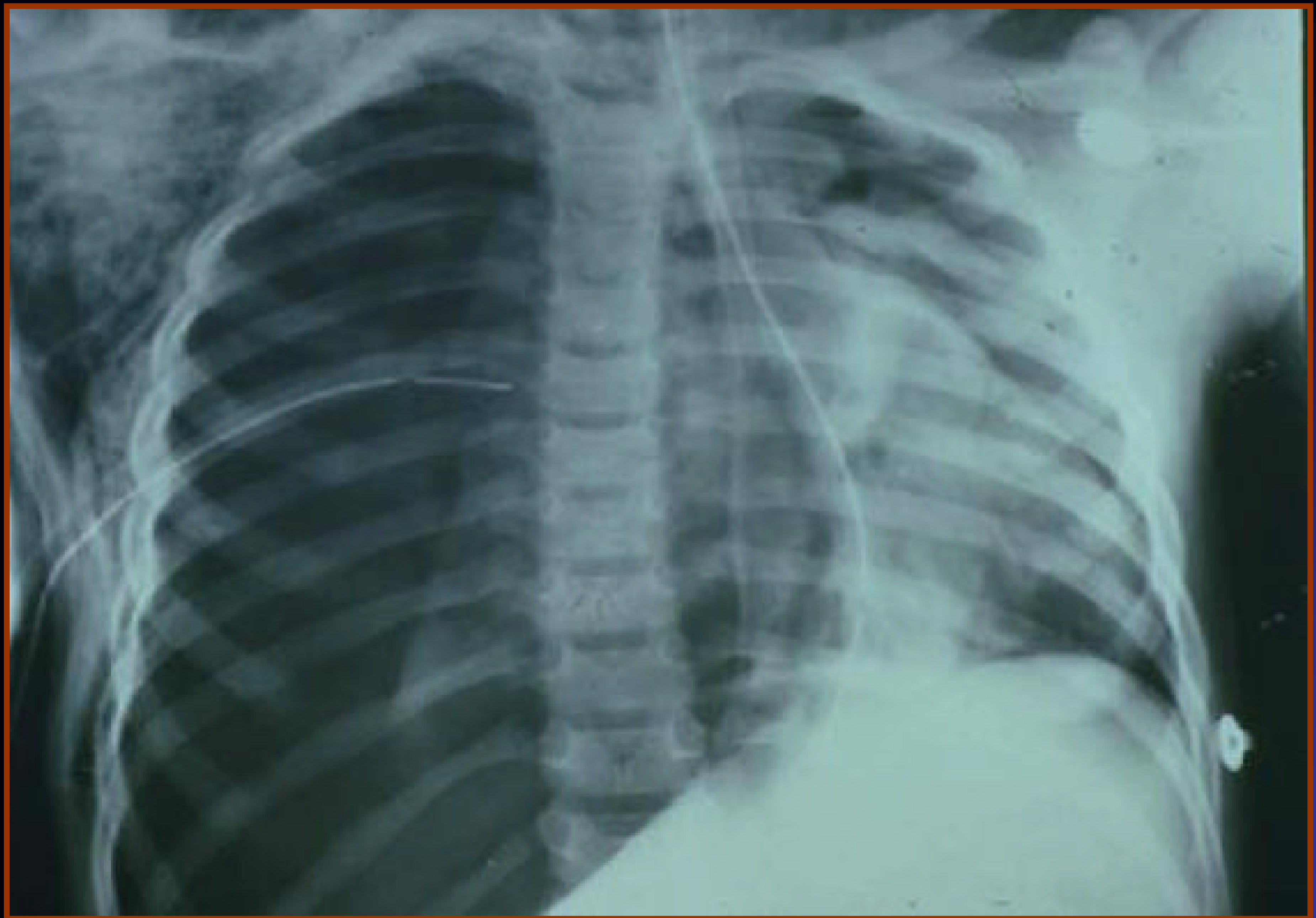
- Variable pulse
- Flat neck veins
- Pale or pink

If you don’t look for cyanosis, you won’t see it

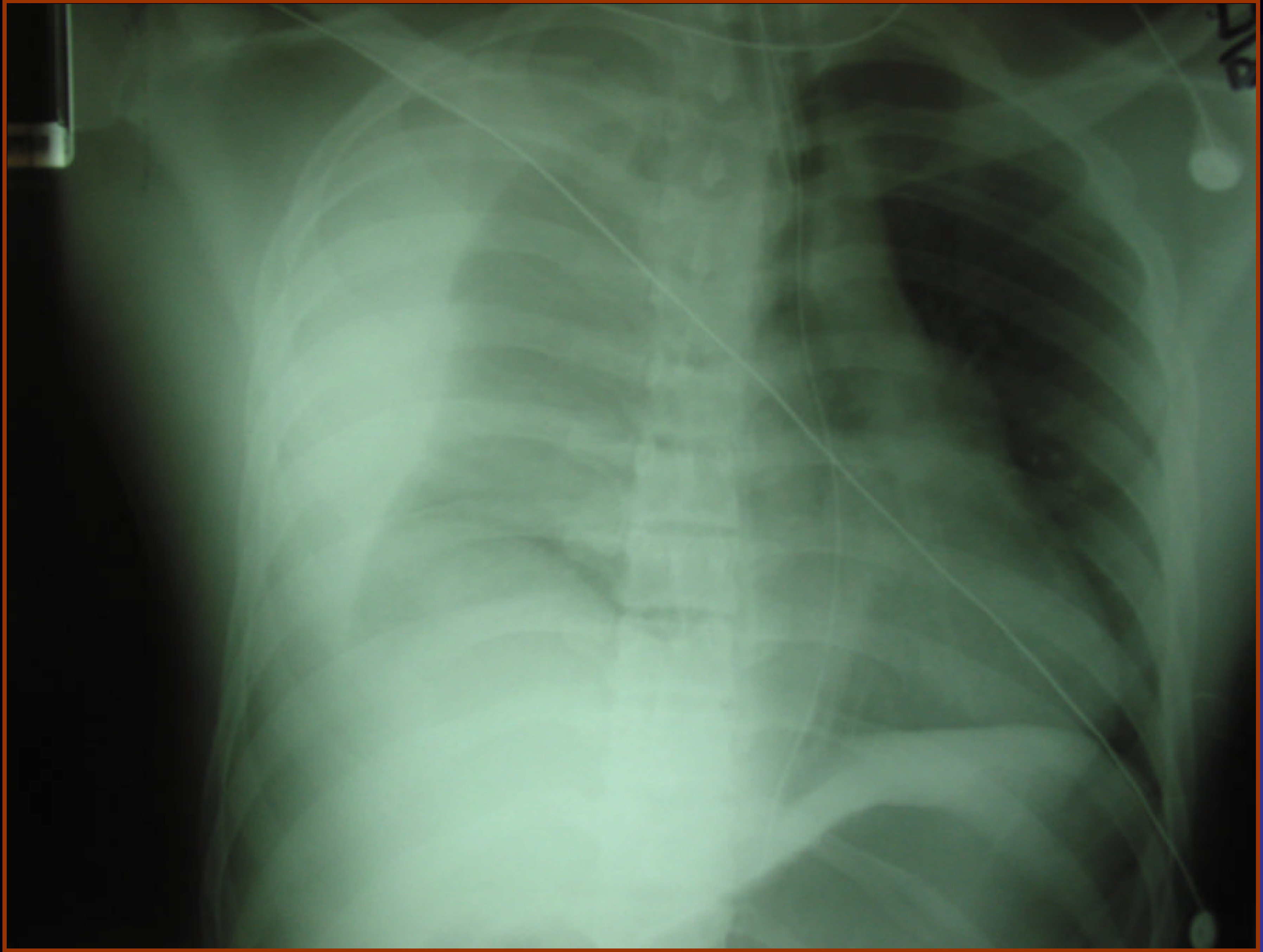


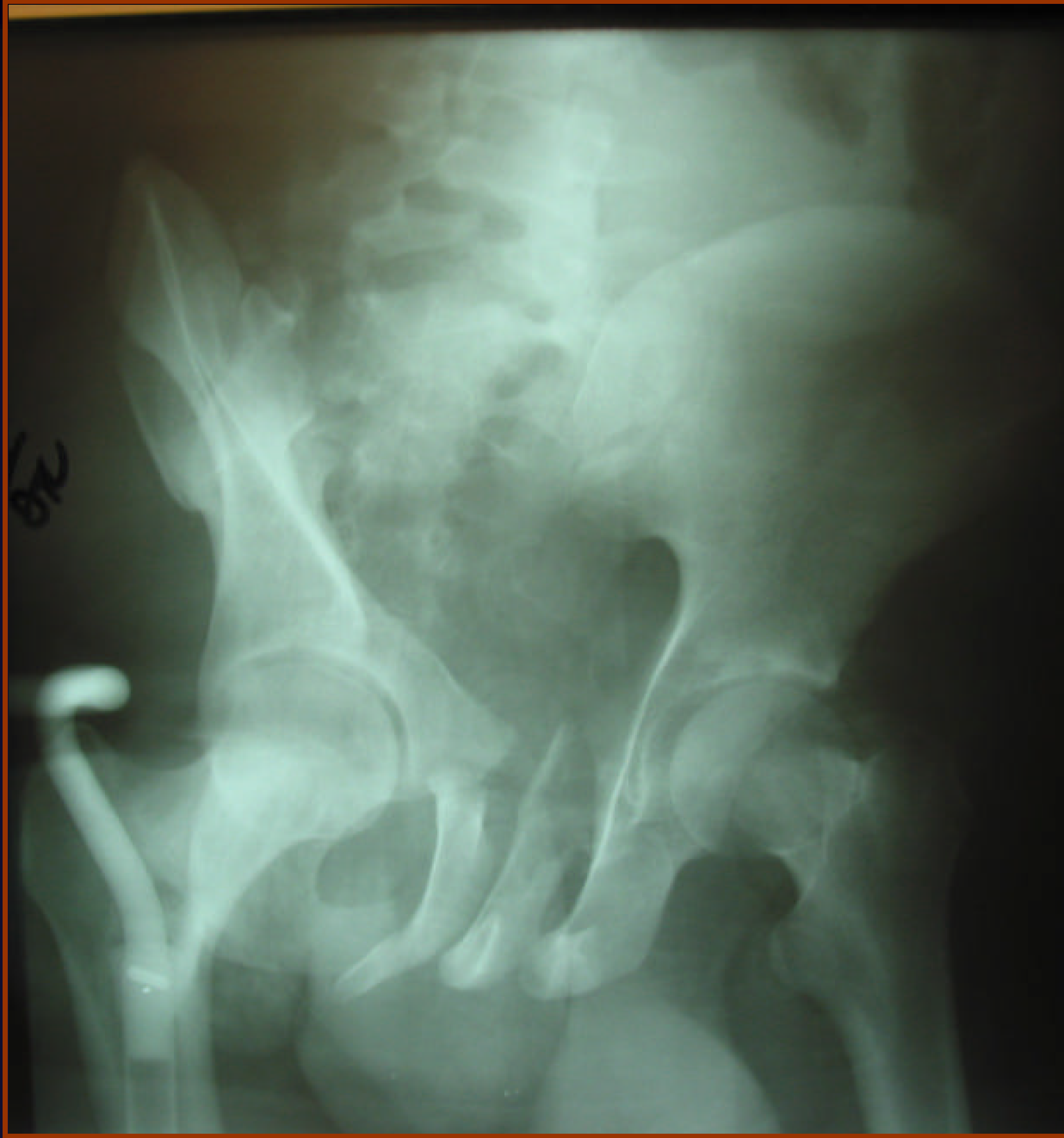
If you don’t LOOK for JVD, you won’t see it

Parkland



Ruling out "positive intrathoracic pressure" is one of the most vital points in critical care





And, my goodness, what DO we DO with waveform capnography in the future of EM??

Only with excellence in physical assessment and commitment to patient service, can the best possible care be given

“The Demise of the Physical Exam”

Sandeep Jauhar, MD, PhD
NEJM 354:548-551
February 9, 2006

“The Stethoscope and the Art of Listening”

Howard Marken, MD, PhD
NEJM 354:551-553
February 9, 2006

SHEPHERD
DR
1400
ONE
WAY
ONE
WAY
AJN-996

7. "It isn't what it isn't…

…it's what it MIGHT be that will get you in trouble…

…and hurt your patient"

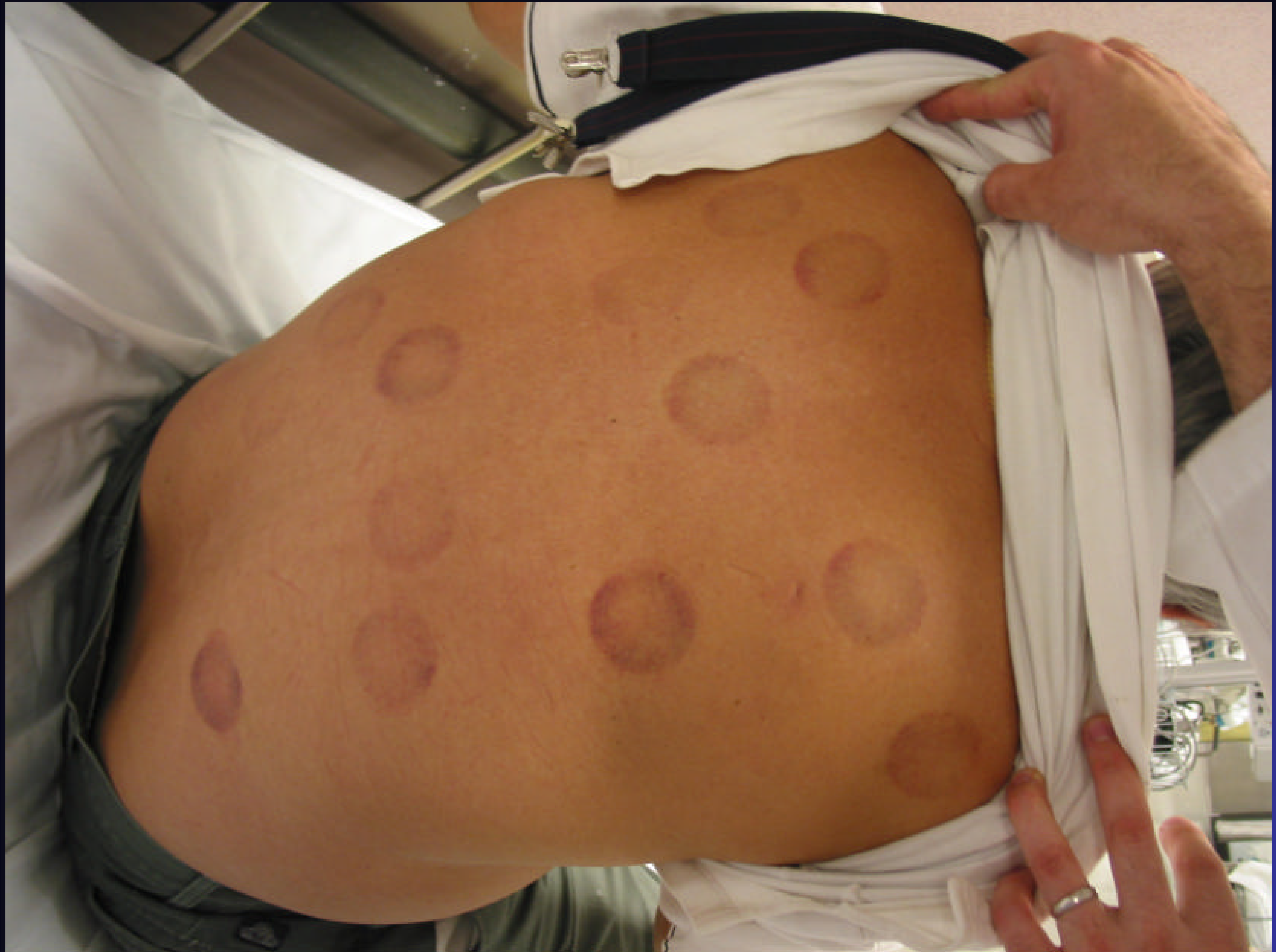
Beware of abdominal pain AT REST, especially in the older patient…

…especially with co-morbid illnesses and (in hospital) elevated WBC's

"The general rule can be laid down that the majority of severe abdominal pains which ensue in patients who have been previously fairly well, and which last as long as six hours, are caused by conditions of surgical import"

The Early Diagnosis of the Acute Abdomen
Sir Zachary Cope
pp 5, Oxford Medical Publications, 1921

The difference between a “specialist” and a “generalist” is in the rigor of the application of a differential diagnosis



What are our abilities to diagnose patients in the ED?

Are there limits?

What diagnostic limits do

YOU

give yourself?

8. We are not heroes...

You do not have to PROVE that your patient will do okay outside of the hospital

Ask yourself, might the patient NOT do well?

There is no "rite of passage" contrary to what you learn from your buddies

"…ah…she'll probably do okay at home"

9. If a person is an insulin-dependent diabetic and has a potentially major problem with another major organ system, strongly consider hospital admission

10. Once the patient is "out the door", (or non-transported) you have lost control of the situation...

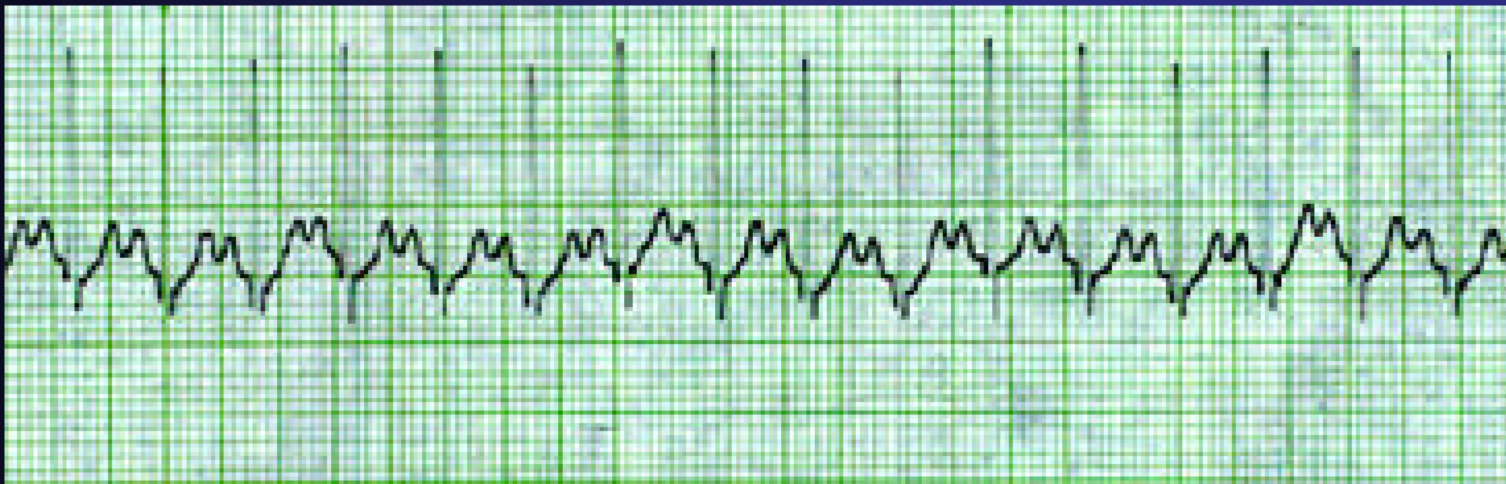
11. Always explain a tachycardia...

Corollary: *Don't depend on the presence of a tachycardia to determine that an emergency is present*

A “physiological response”

Remember:

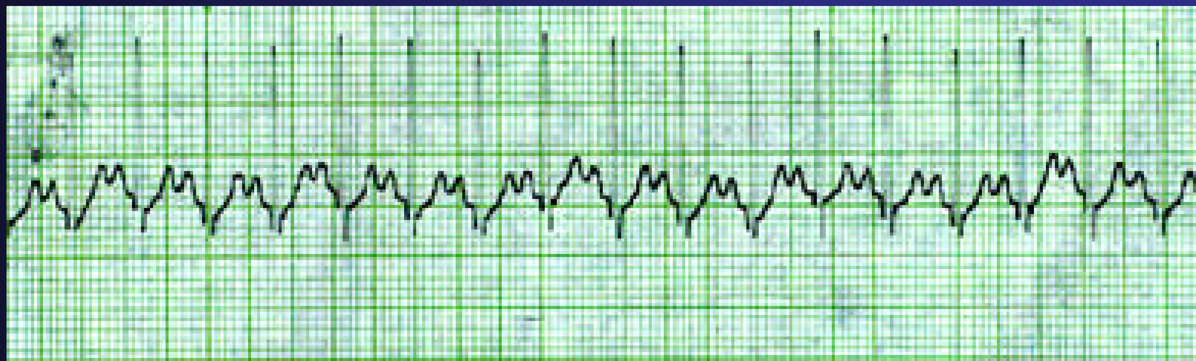
The Maximum Sinus Tachycardia for a patient is about 220 - age



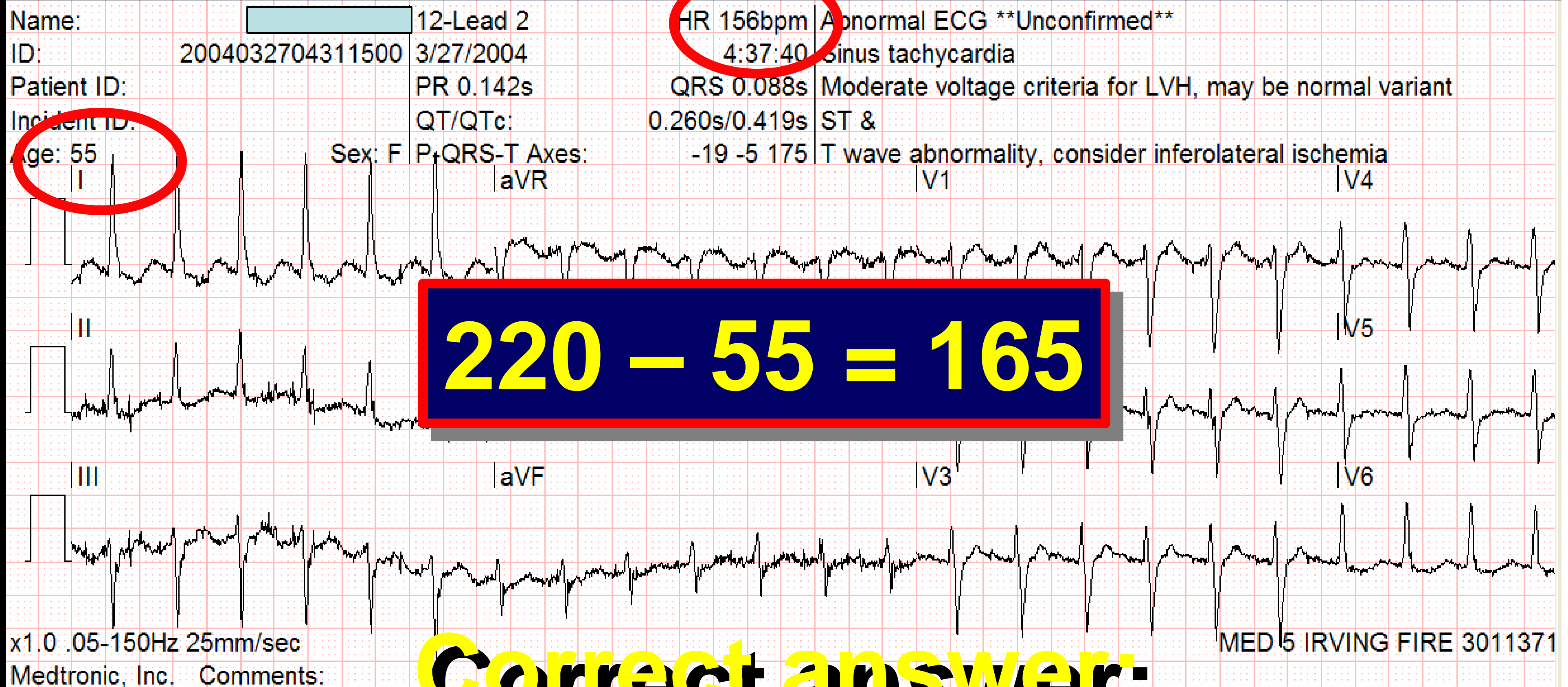
Baby = (220 – 0) = 220

Snerd = (220 – 54) = 166

Aunt Minnie = (220 – 70) = 150



What is this rhythm?



Correct answer:

"It COULD be sinus tach"

If you forget everything else that I say:

Remember that patients having near maximum sinus tachycardia at rest are dying!

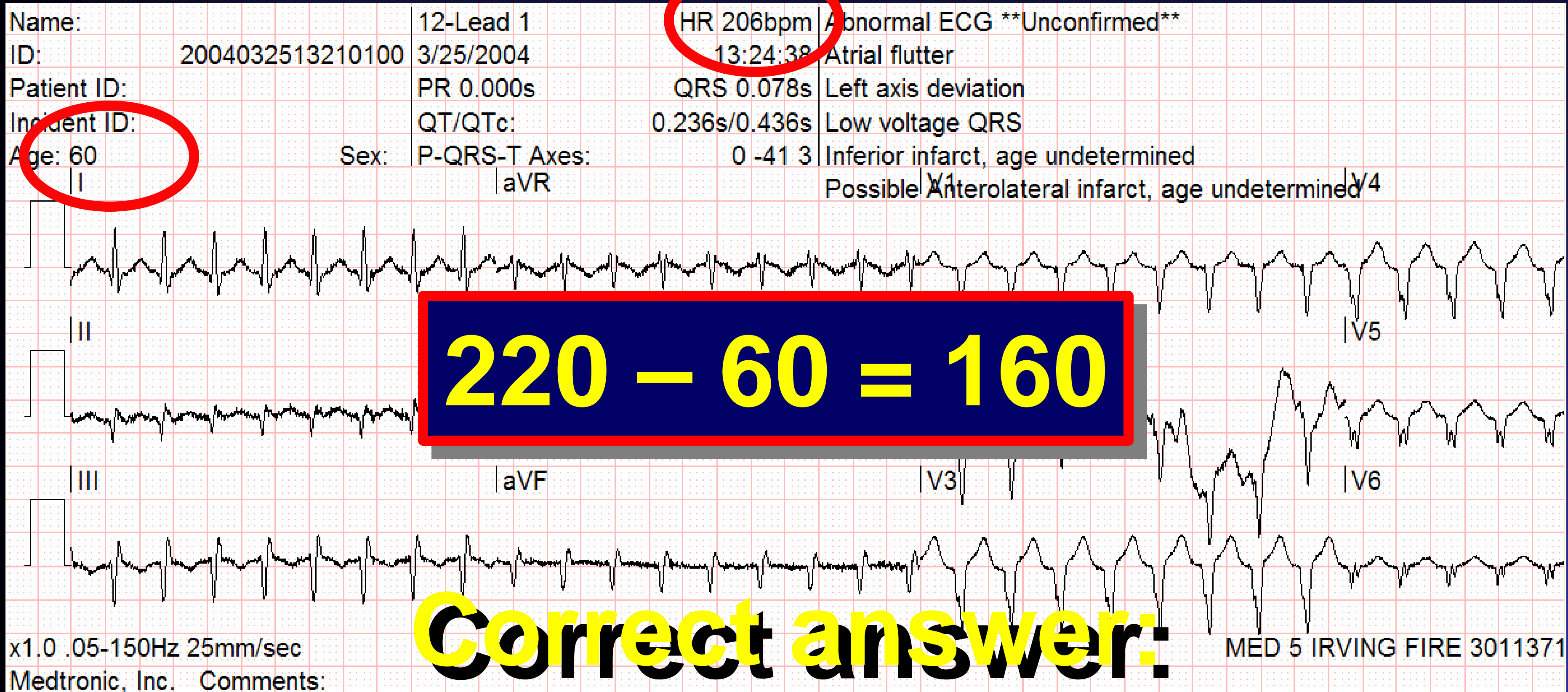
Hemorrhagic shock
Sepsis
Tension
Tamponade
Ruptured aorta
Ruptured ectopic
Massive P.E.

Something mobilizing a massive physiological response

Your job is to determine if a rapid rhythm MAY be sinus tach

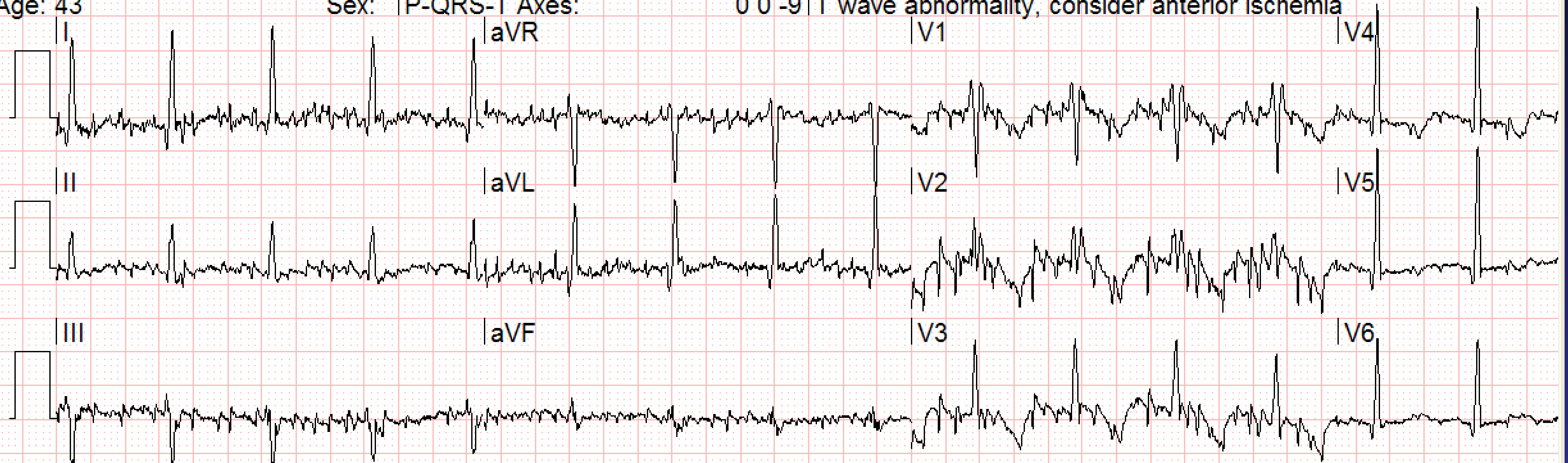
If it is, you must take action

What is this rhythm?

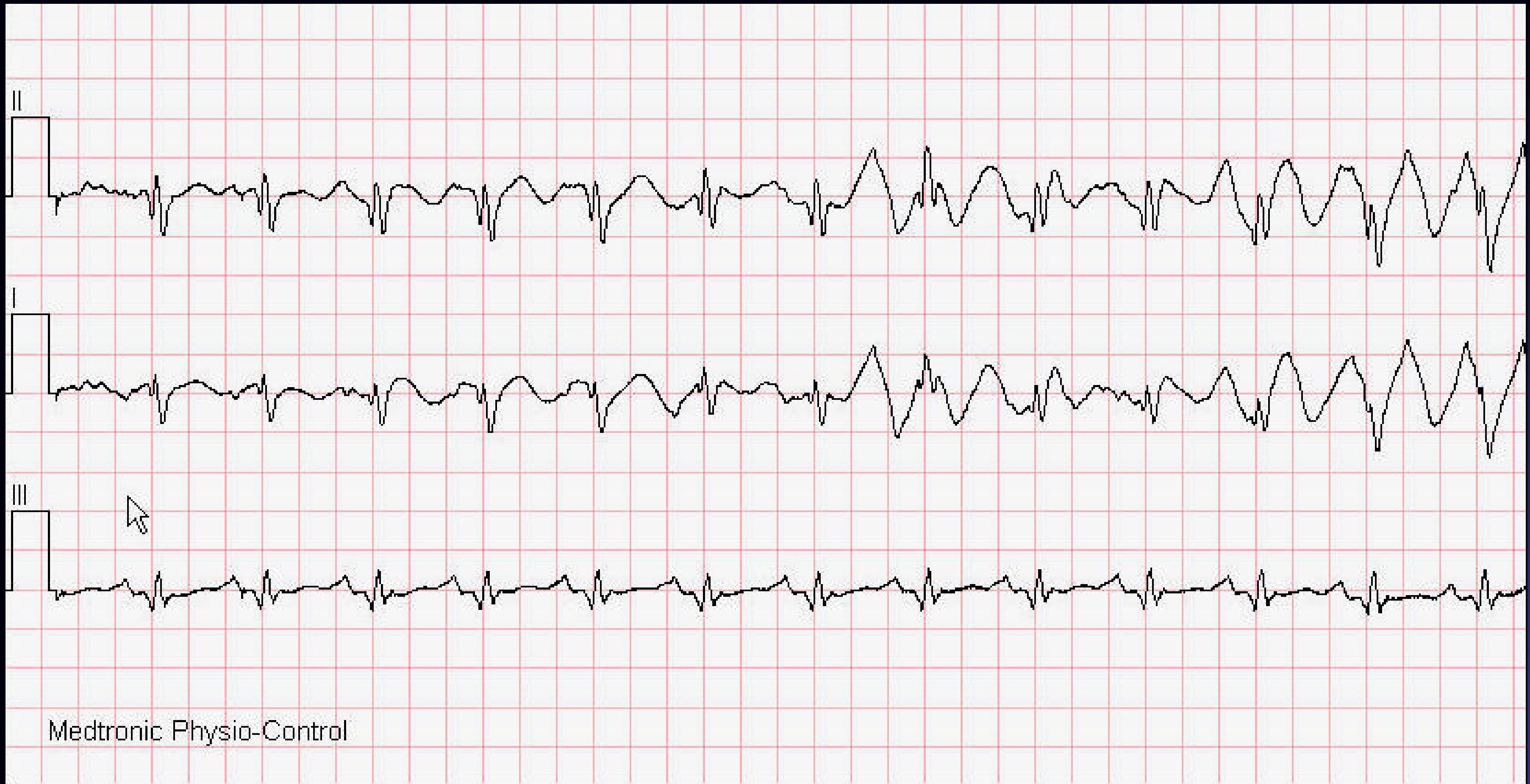


Correct answer:

"This HAS to be an arrhythmia



What is the ambient temperature?



What is the patient's blood pressure?

The most common cause of tachycardia in Parkland ER is probably albuterol…

…followed by amphetamine, cocaine, sepsis, DKA…

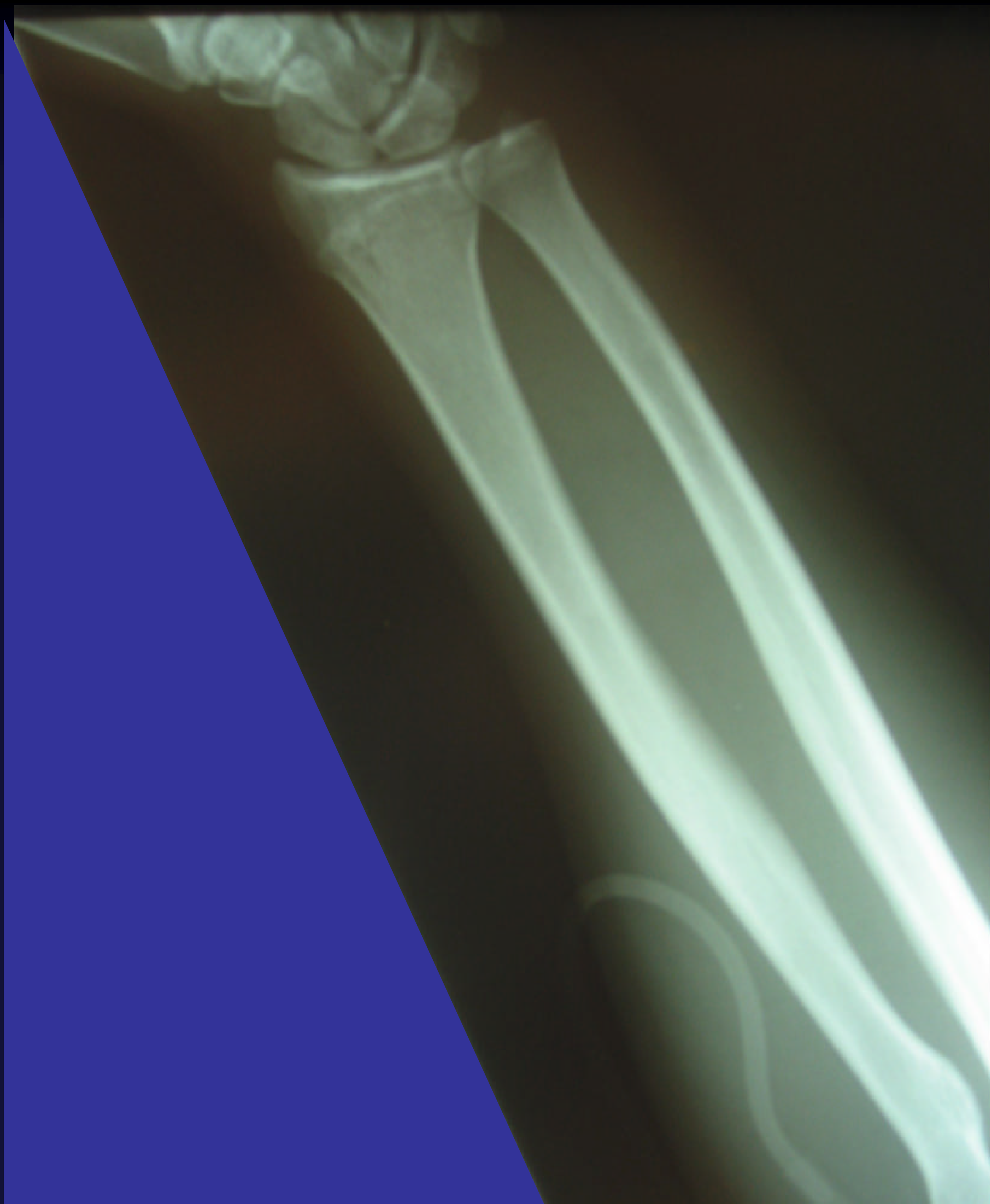
The most common cause of bradycardia in Parkland ER is probably beta blockers…

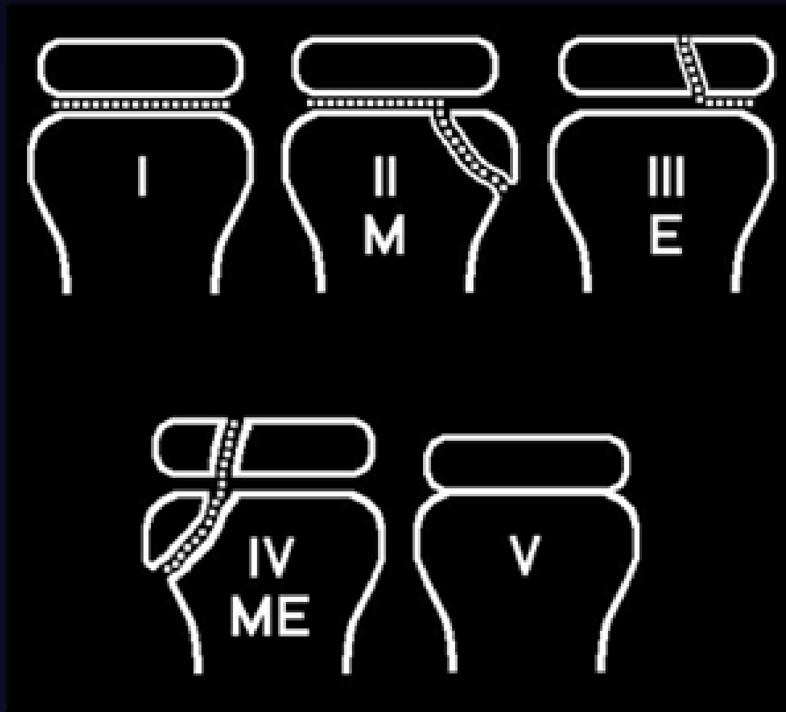
…probably ISN'T great physical conditioning…

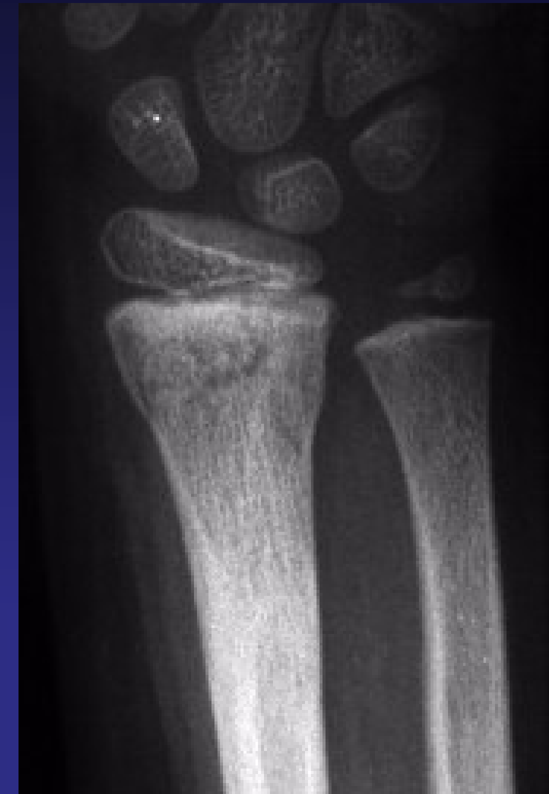
The incidence of bradycardia post-hemorrhage, especially intraperitoneally, is published to be as high as 7 to over 20%

12. If it's blue, it's broken...

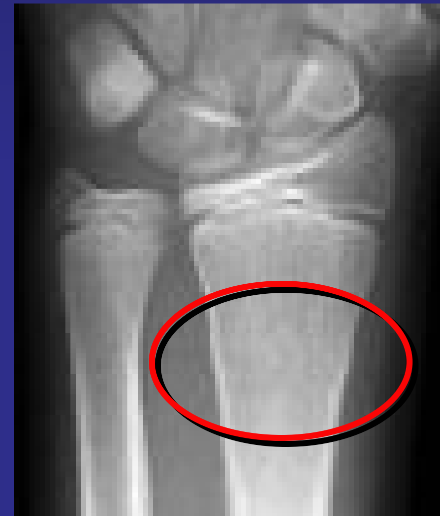
If someone "FOOSH's", AND you find swelling OVER a bone of the involved extremity, that is a fracture



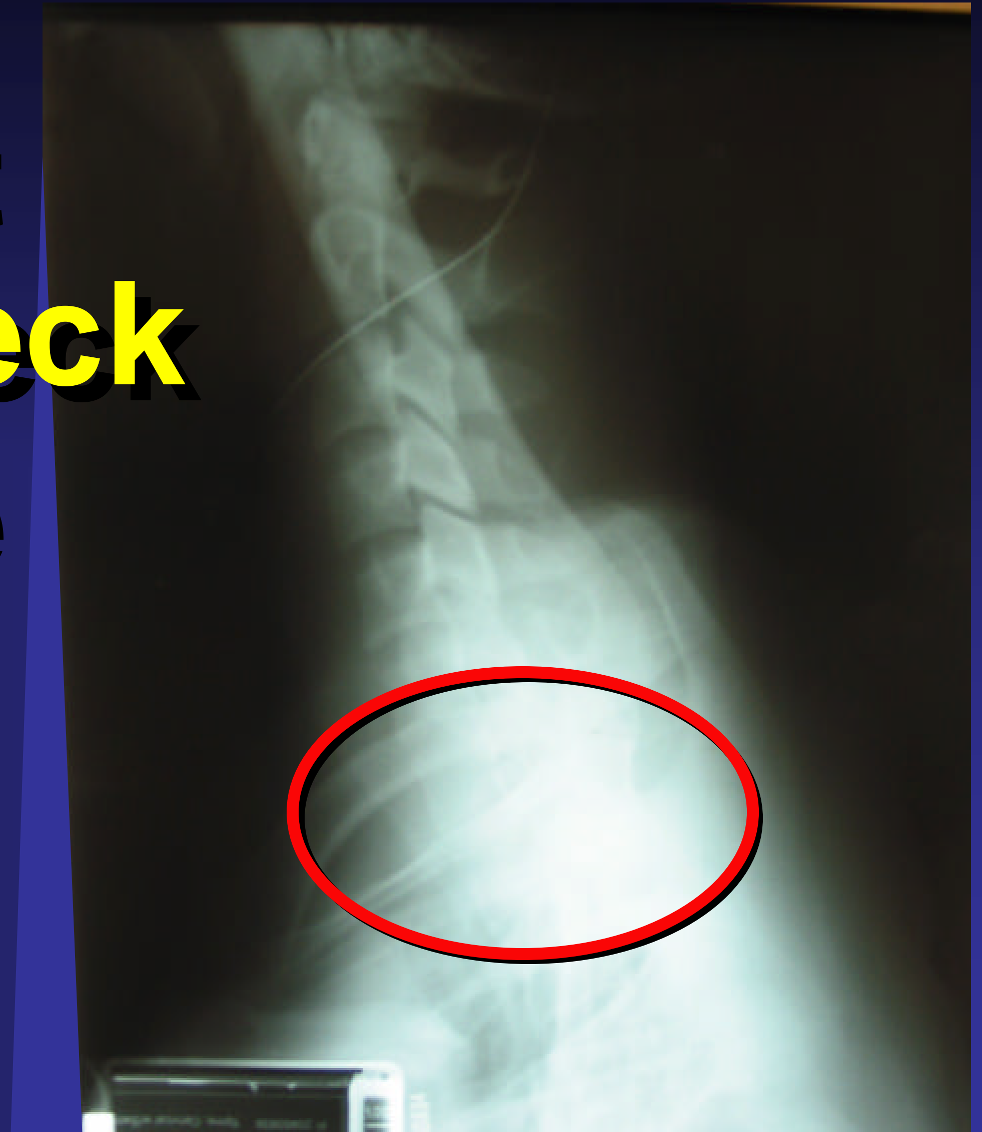

I
II
M
III
E
IV
ME
V

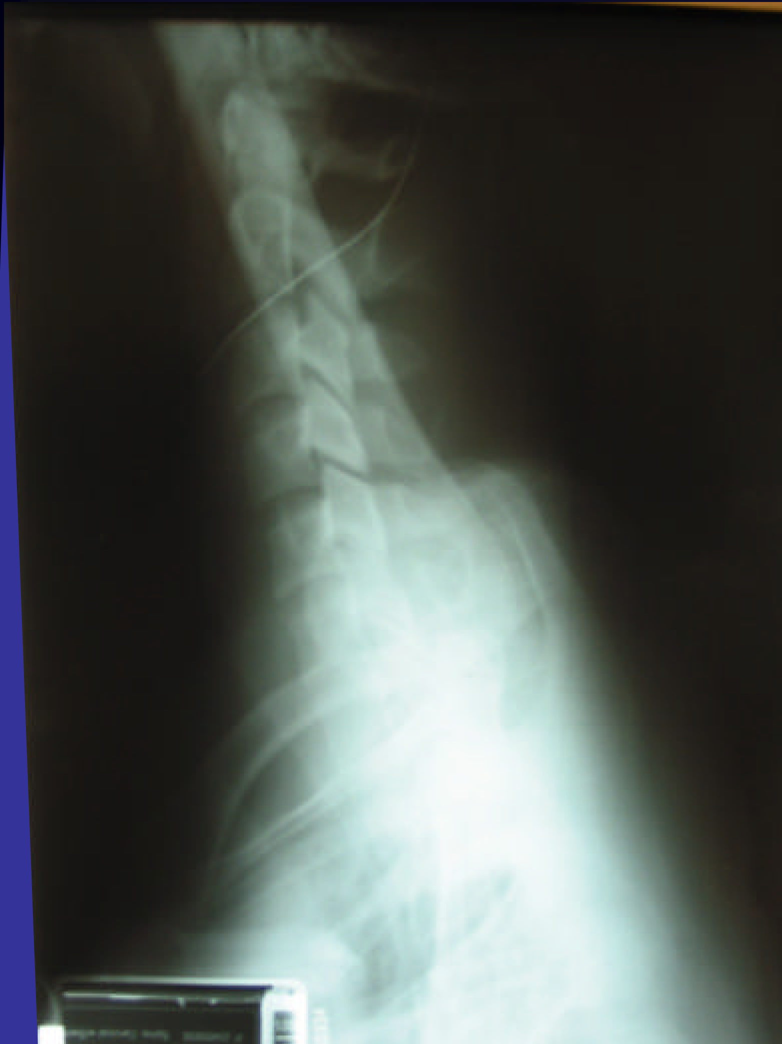


A doughy edema over the distal forearm of a kid after a fall (even with a normal x-ray) is a fracture

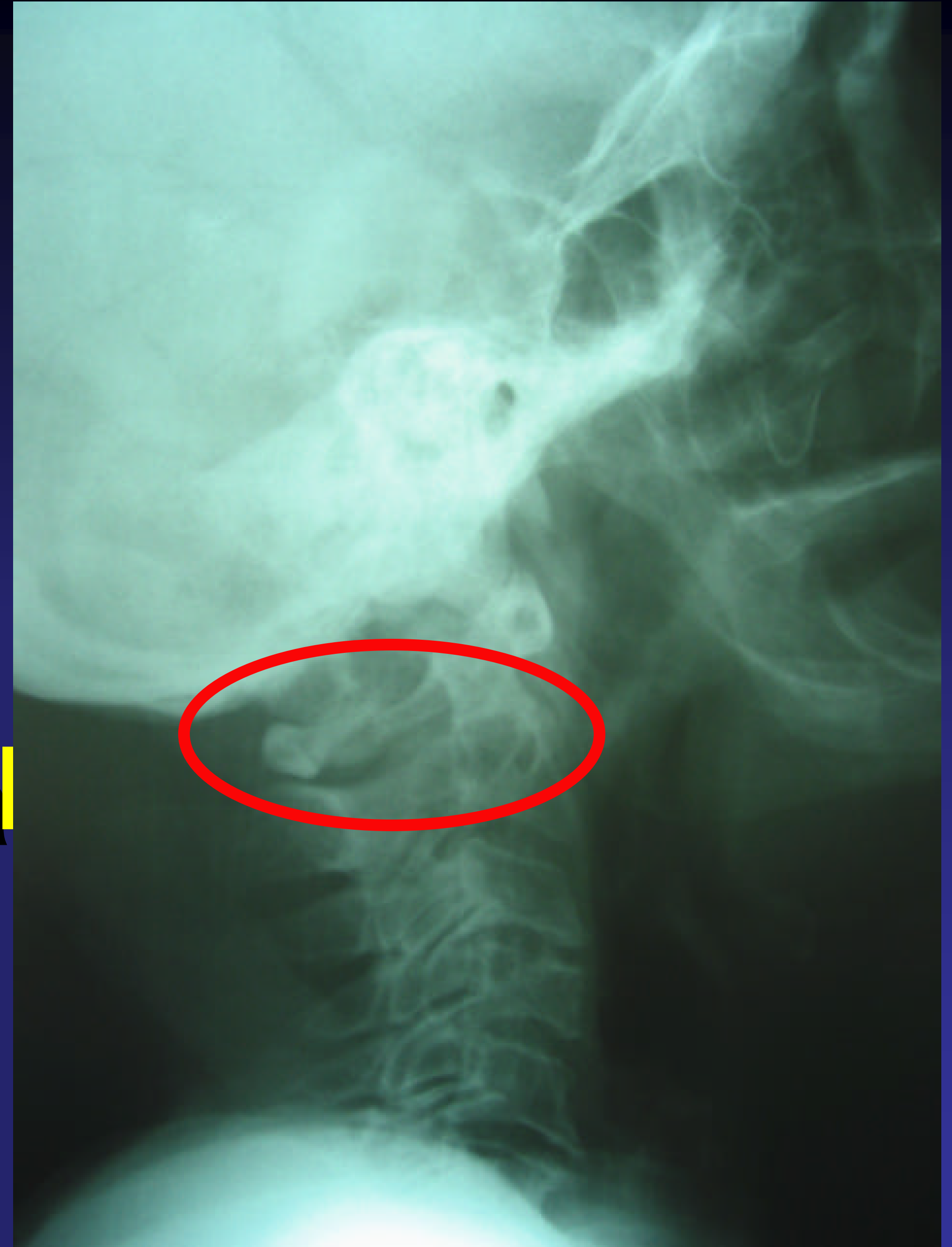


And,
you haven't cleared a neck until you've seen T1



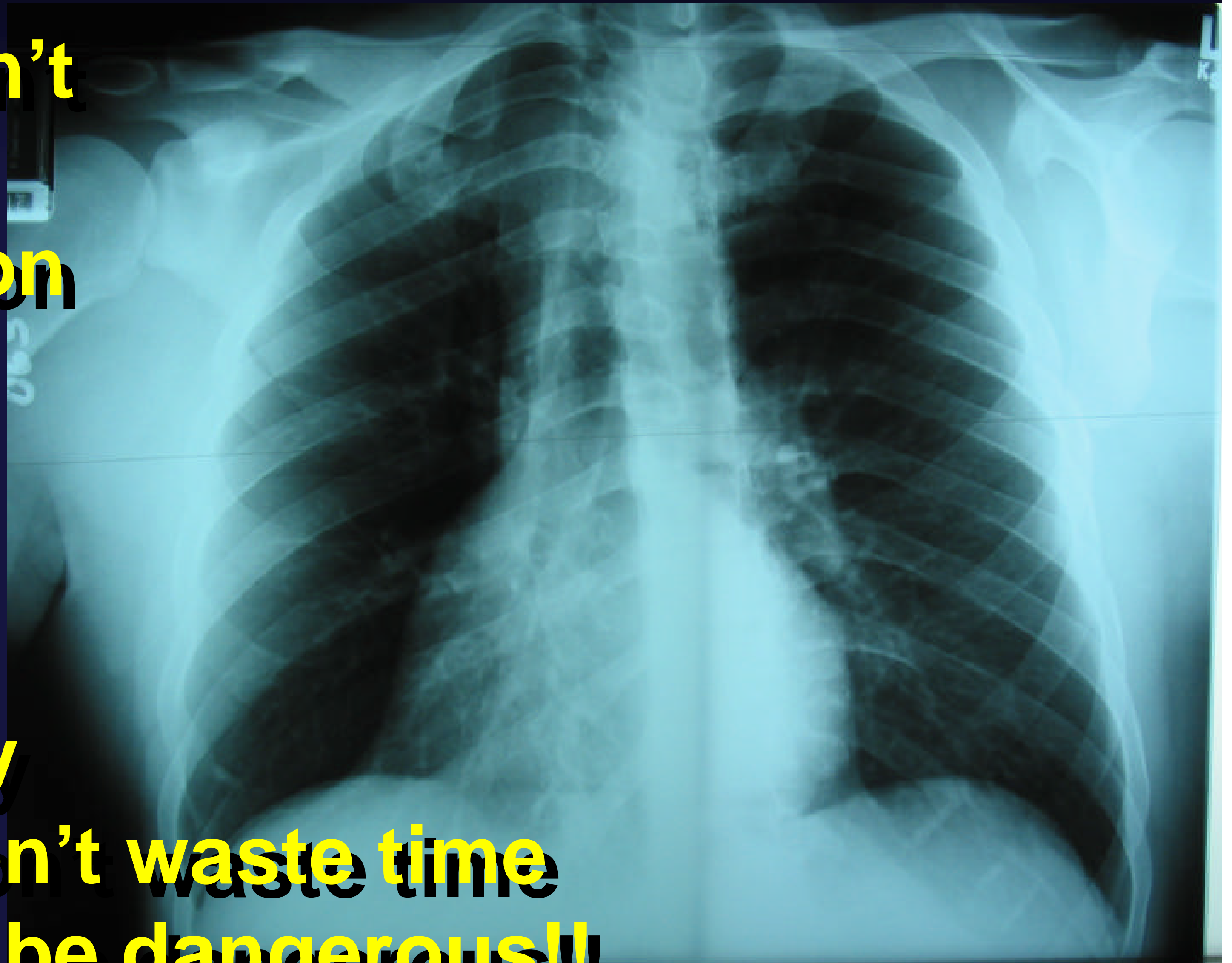


And, don't assume that something potentially serious is an anatomical variant until you've proved it



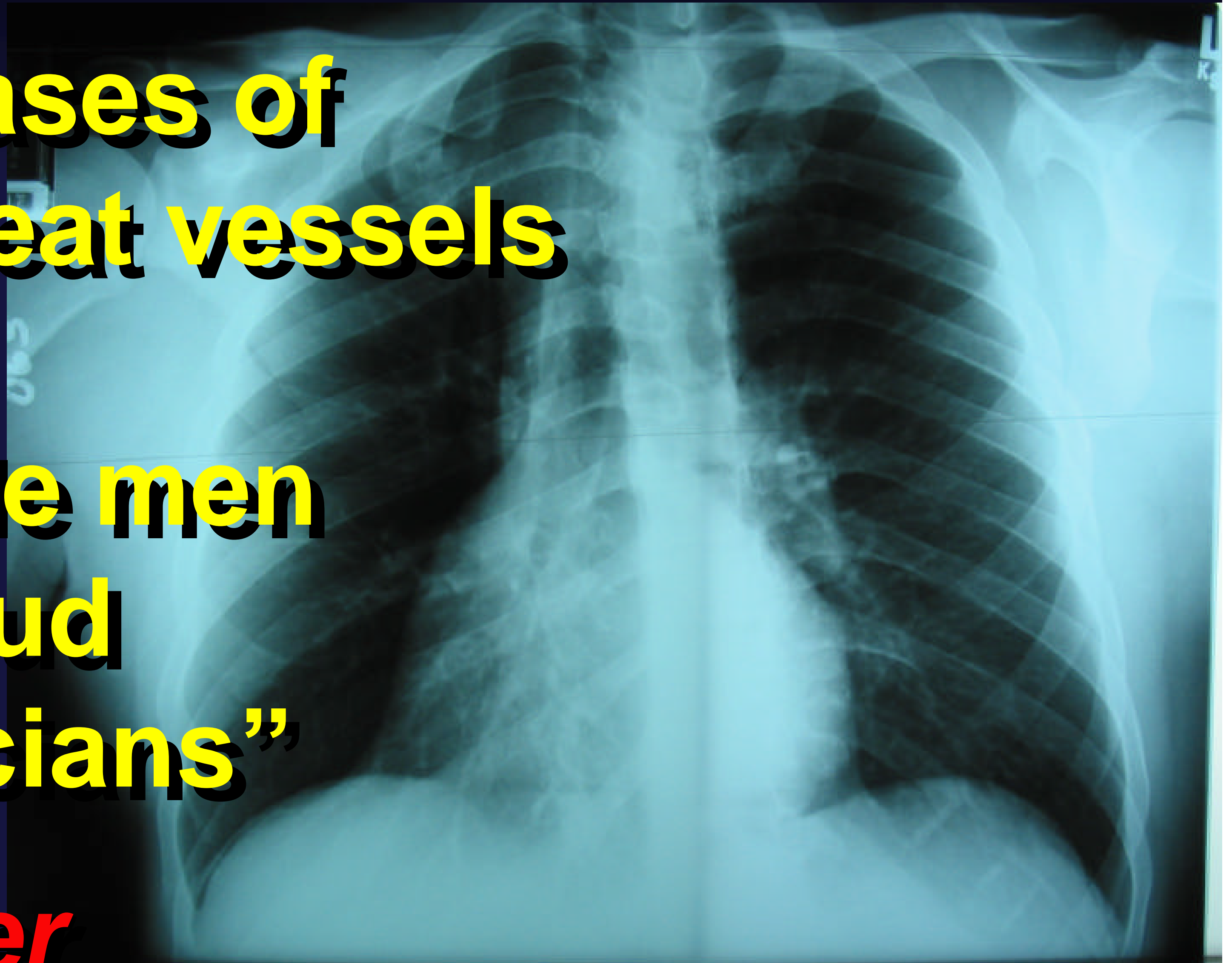
And, don’t chase a finding on a study until the study is done correctly

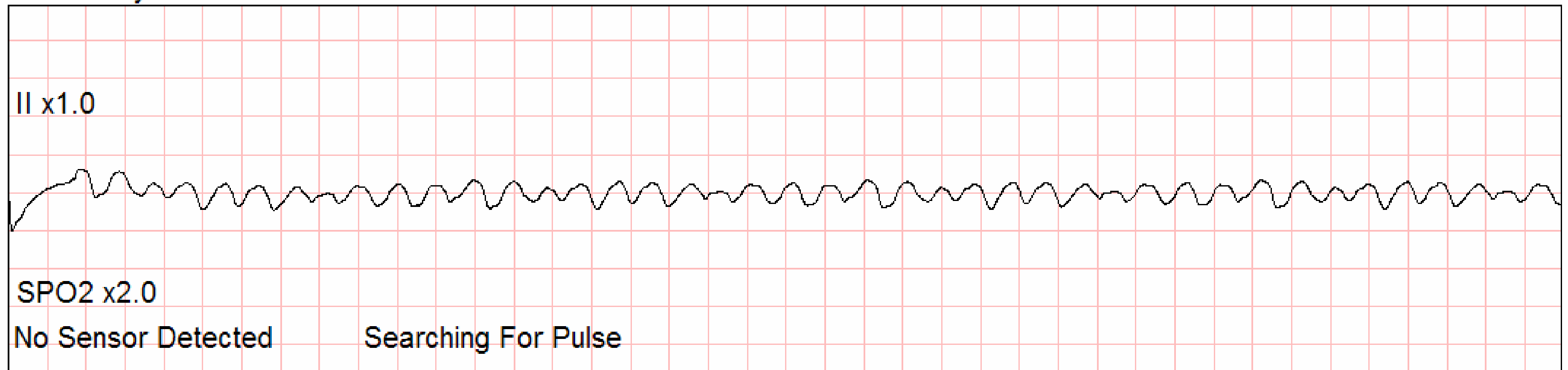
…but don’t waste time if it may be dangerous!!



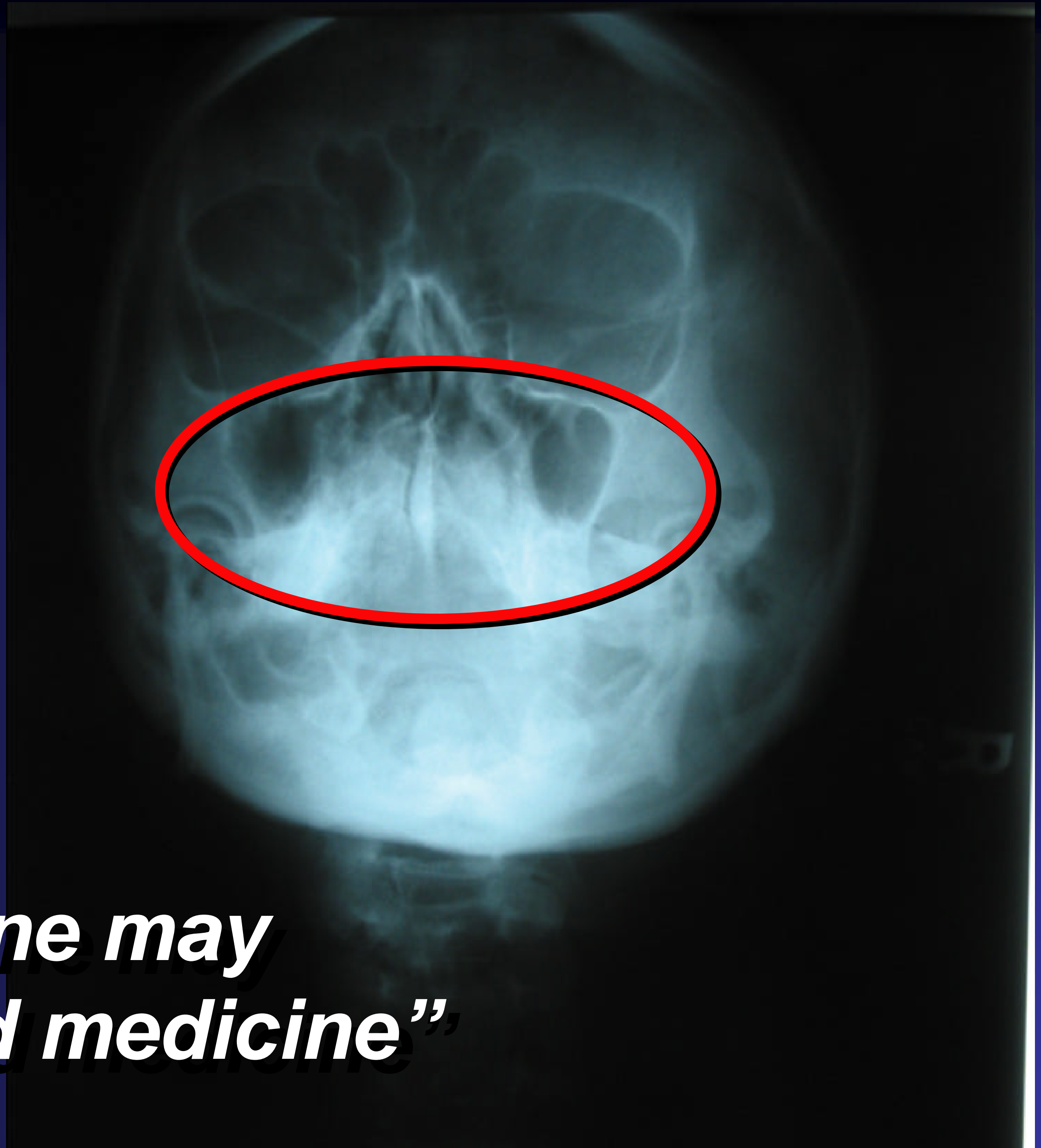
“Diseases of the great vessels make humble men of proud physicians”

…Osler



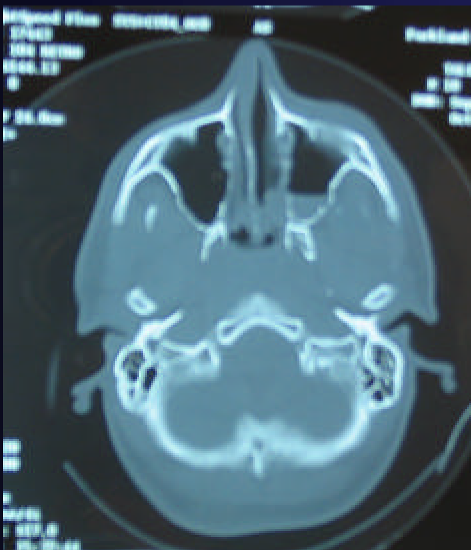

Initial Rhythm
II x1.0
SPO2 x2.0
No Sensor Detected
Searching For Pulse

Don't be afraid to learn to read a plain skull film…



"old medicine may still be good medicine"

Just remember that a normal plain skull and spine film really means NOTHING!!!



13. Never send home (or non-transport) a sleepy baby that doesn't come to full wakefulness

Corollary - If the baby vomits his dose of medication, be careful unless you've seen the LP results

14. Give the first dose of medication before the patient is released from care...

...whether transporting or NOT!

The most closely associated factor affecting morbidity and mortality of patients seen in the ED with pneumonia is

TIME TO FIRST DOSE OF ANTIBIOTICS!

15. A normal EKG rules out nothing

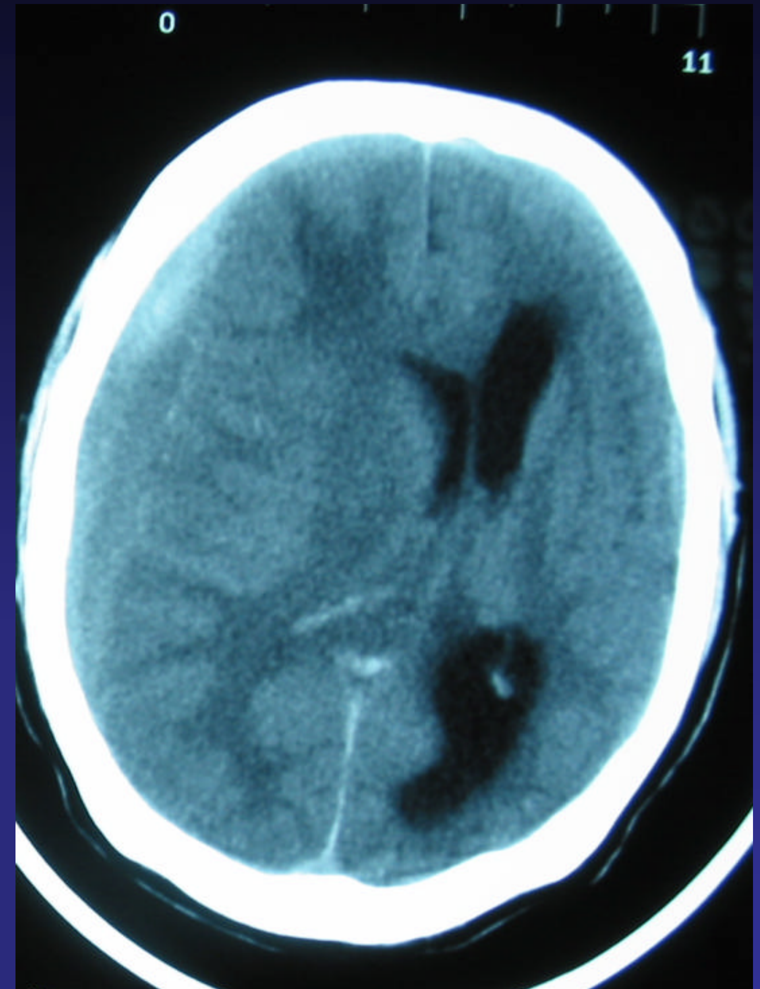
16. AMS ALWAYS means that something is wrong...

…until you prove it otherwise...

The “computer” will come to “full on” in everybody unless there is a chemical or structural abnormality…

Corollary -
If a patient,
post head trauma,
is lying quietly
and then
STOOLS IN THE BED,

the patient has
a subdural hematoma
until proven otherwise



…and, perhaps most importantly….

17. You have to look HARD for a reason NOT to give a dose of Ativan to a patient in Parkland ER!!

Other postulates

- ***"Back pain, leg weakness, stat MRI"***
- ***"Don't you want to get a pregnancy test before that abdominal x-ray, doctor?***

Violence in the Emergency Department

Anticipate

Do NOT INFLAME the Situation

Evaluate

Get enough help

Sedate as needed:

Versed is good – IM, IN, IV

Other sedatives

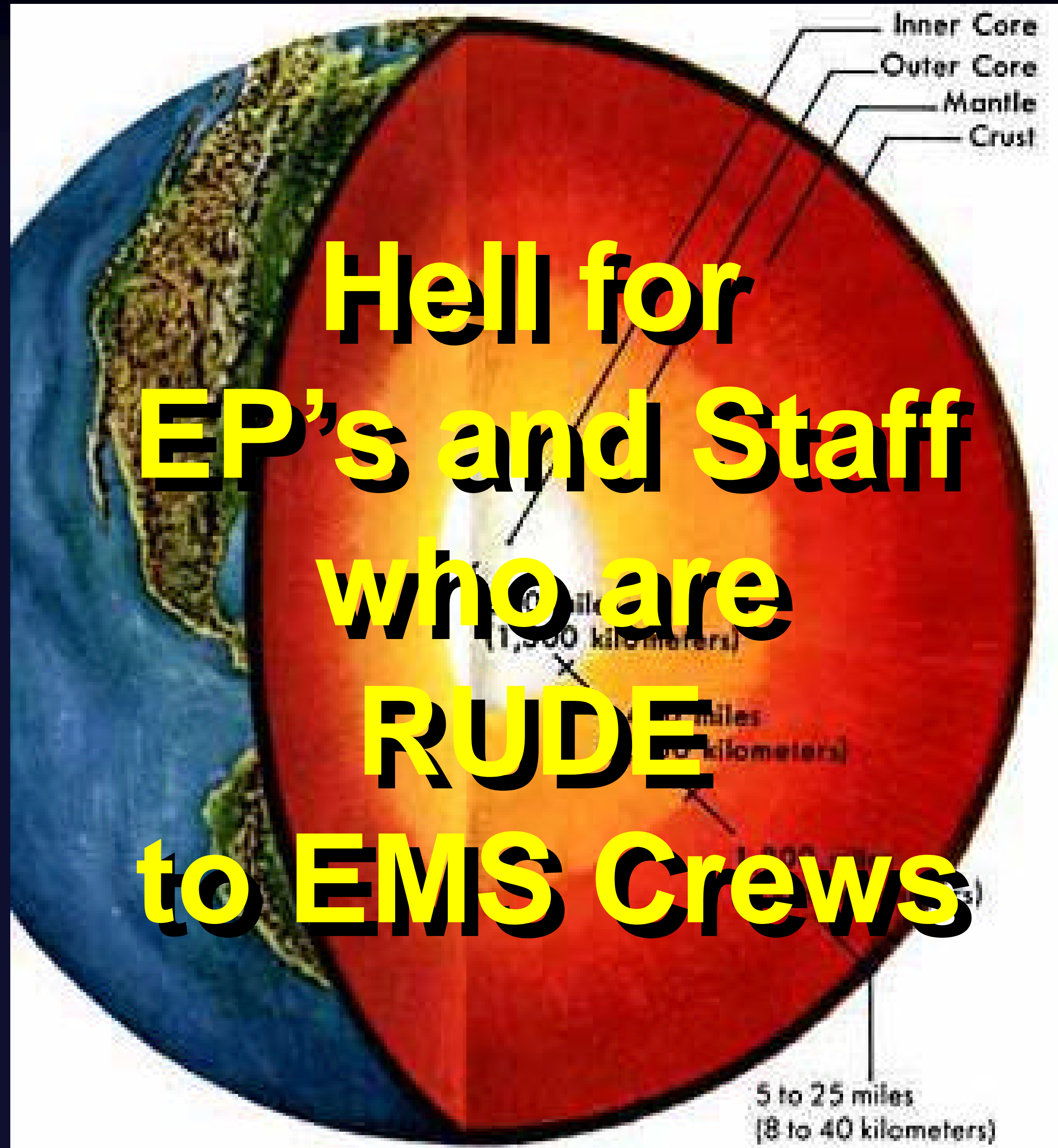
TASER

Sux Blow-dart

ALWAYS Remember:

Once you've taken somebody down, you are fully responsible for them

Finally!!!



Hell for EP's and Staff who are RUDE to EMS Crews

The
Golden Rule
of Survival in
HOSPITAL
Emergency
Department
Life

The Nurses RUN the Hospital!!

When in doubt, re-read the rule!

Survival is the key…

…wining "skirmishes" means nothing

Bribery does not work, and you'll only be fooling yourself

We'll Kick Your Ass
County
SHERIFF
And take your doughnuts too!

www.UTSW.ws
www.rayfowler.com
drray@doctorfowler.com

Godspeed…

…and be careful…

? or !