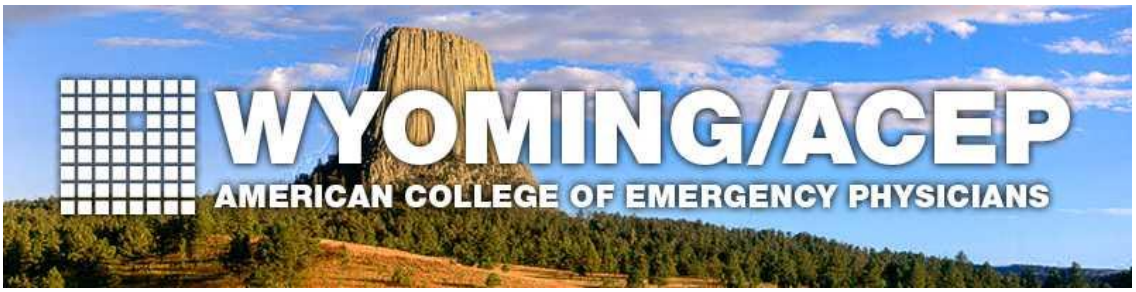
A Newsletter for the Members of the Wyoming ACEP Chapter



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From the President
Buck W. Wallace, MD, FACEP

You know it's spring in Wyoming when you can finally smell the dirt and the snow is only intermittently falling!

I have been watching Sublette County, WY struggle with the possibility of building a critical access hospital. I think the issues they have faced are issues paramount to Wyoming healthcare. The hospital industry doesn't look particularly rosy these days. Although the number of for-profit hospitals is on the rise, over-all the number of hospitals is declining, down from 6,100 in 1997 to 5,564 today.

What makes up the decline? The number of non-profit local community hospitals and state hospitals which have closed.

Why are smaller hospitals closing? Nationwide since 2013 admissions are down over 6% yet expenses rose from $859 billion to $936 billion during that same time. More than a half of U.S. hospitals lost money on operations last year. The trend is for smaller systems to merge with larger systems or face closure. The added pressures of Advanced Payment Models (APMS) and complex reporting requirements, two aspects of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), will likely push further consolidation.

A report from the Kaiser Family Foundation in July 2016 entitled " A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies", summarizes that for small rural hospitals, "local residents and public officials often lack the expertise or experience needed to negotiate with large corporate health systems and have limited understanding of the transformation taking place in healthcare delivery and payment systems widely". Yet, that same study also stated when hospitals focused on margin instead of mission, they are likely to fail. Although I am not for it, Medicaid expansion in Wyoming could help at-risk rural hospitals by increasing the insured. Right?

A recent study found that while rural hospitals were showing declines in free care as a result of the ACA, the net financial impact was less clear because of bad debt from high-deductible plans as well as “shortfalls” between payments and costs of care in Medicare and Medicaid. Some suggest true critical access hospitals in Wyoming might fare better than "rural hospitals" in parts of the country where a larger hospital may be 20 miles down the road. I am eager to see how the Trump administration's current plan will affect Wyoming hospitals already suffering from financial downturns in their local communities.

Also, this month, Dr. Carol Wright Becker from Cheyenne Regional Medical Center presents an interesting case. Please submit your interesting cases, comments, tricks-of-the trade to **Adriana Alvarez**, our Chapter Administrative Assistant for the next quarter e-newsletter (due Monday, August 28th).

From the President-Elect
Carol Wright-Becker, MD

VT Armageddon

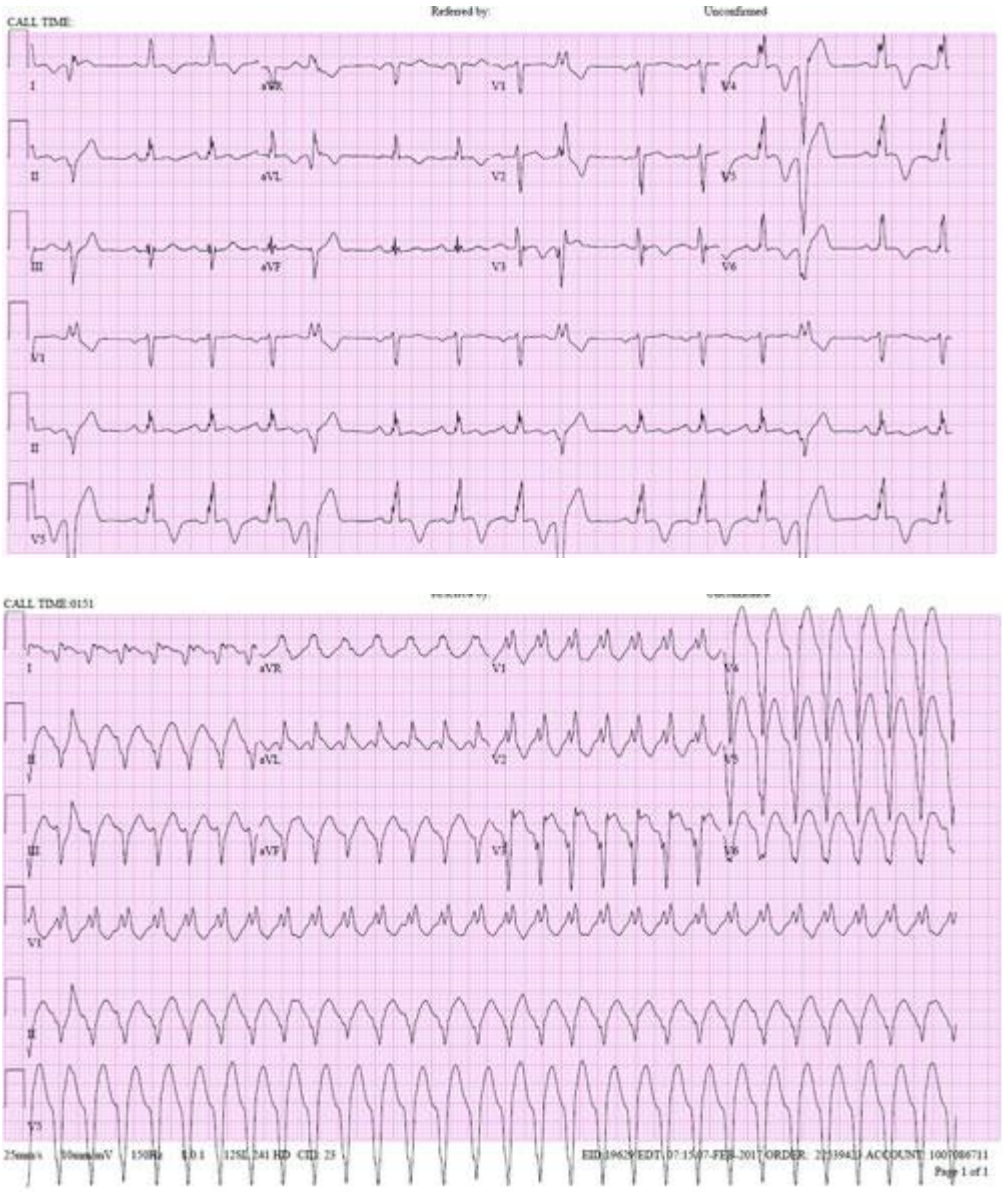
After a long night in the ER another patient arrives with the chief complaint of palpitations. You get ready for the usual electrolyte check and benign EKG. However, when you walk into the room you get a surprise. In front of you sits a very pleasant 68 year old male who reports he was at home when his defibrillator began to fire repeatedly. He estimates that it may have fired as many as 30 times. He feels well on presentation but is very anxious that it could start up again at any time. After getting additional history you see that he has a history of hypertrophic cardiomyopathy. The usual electrolytes come back normal and the EKG consistent with HOCM. You touch base with the on call cardiologist and they recommend admission with AICD interrogation in the morning...reasonable.

And then.....

From a few rooms down you hear the patient start screaming. You rush to the room to find him clutching his chest is agony. On the monitor you notice he is in V tach. You get your ACLS mind ready and start the usual protocol of amiodarone 150mg push and drip and you attempt synchronized cardioversion...no luck. You now find that per Biotronic interrogation that he was shocked 37 times at home prior to arriving in the ER. With each shock he briefly converts to sinus rhythm but quickly reverts back to V tach. You start to think outside the box by adding Magnesium, Lidocaine, Procainamide, even dual defibrillator cardioversion and still... no luck. You consult every specialist that you can think of and they offer little more than "run the code" -- we are SOOO past this. After roughly 30 shocks from his defibrillator in rapid succession, we elect to intubate the poor guy given the pain. Still…V tach. You start a Lidocaine gtt, more double shocks, place a magnet over the chest and...no luck. Still…V tach. To make things worse the blood pressure is now 68/49 via an a-line you placed when he had been running 156/86. With the magnet in place you attempt overdrive pacing and still...no luck. At this point, you are at about 75 shocks between the code cart and the defibrillator. You start to push more fluids and give another Amiodarone bolus this time 300 mg. At last the cardiologist has arrived to bedside and despite the low blood pressure the decision is made to push Labetalol and....SUCCESS. Sinus rhythm is achieved and we initiate levophed and phenylephrine for blood pressure stabilization.

This gentleman was admitted to the ICU and had persistent runs of V tach. They had to replace his defibrillator and his EF was initially found to be 30%. Fortunately, it improved to 60% in short time mitigating the need for potential heart transplant. He is pending another attempt at ablation. His defibrillator settings were change to fire at 214bpm from the previous 188 bpm. Ultimately, it was estimated that he received 193 shocks between attempts in the ED and his own device. A true VT Armageddon!

The above was written by Carol Wright Becker, MD and Matt Loptein, MD with patient permission.



Adriana's Corner

ACEP17 is just around the corner. I hope your schedule will allow for you to attend at least one or two days of the awesome educational program that national ACEP is preparing this year.

The chapter is planning to have a **leader** of national ACEP visit the chapter. If you have any

suggestions about who should visit you in Wyoming and what topic should be presented, please send your ideas via **email** to the chapter.

In the meantime, if I can be of any assistance, please feel free to **email** me.

Clinical News

Antibiotic Therapy for Abscesses Medical Dogma Challenged by Evidence-Based Research, Outcomes
Have you wondered when you'd start to routinely confront superbugs resistant to multiple antibiotics in your emergency…
Read more...

Should Emergency Departments Do Fewer Red Cell Transfusions, More IV Iron?
You might be surprised to learn that many of the patients who receive red cell transfusions in…
Read more...

Treatment for Acute Gastroenteritis, Acute Epididymitis in Pediatric Patients
The best questions often stem from the inquisitive learner. As educators, we love, and are always humbled…
Read more...

New! "ACEP Trauma, Stroke, and Cardiovascular CME Collection"

The "ACEP Trauma, Stroke, and Cardiovascular CME Collection" includes 48 lectures with downloadable syllabi that will help you meet your requirements.

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