

IVF for blood products: always NS

**PRBC** for acute blood loss or symptomatic anemia. Never give if hgb M>10, F>7

Adults: 1 U PRBC (peds 3 cc/kg) → ↑ H/H by 1 / 3

Usually 1 U over 60-90 min, but w/in 4 hrs. Can give 50-100 cc NS to ↑ rate

**Plts** Give for < 20,000 or < 50,000 and oozing or going for procedure

1 U plts → ↑ plts by 5 x 10<sup>3</sup> No ABO match but match Rh.

Usually give adults 6-10 U, peds 1 U/10 kg

**FFP** 1 ml of FFP is ≈ 1 unit of activity for any clotting factor.

For warfarin reversal give 5-8 ml/kg. Otherwise, for 30% of nl plasma factor concentration, give 10-15 ml/kg. Each unit contains 150-250cc FFP.

Viral Transmission Risk	
Hep A	1:1,000,000
Hep B	1:30,000 to 1:250,000
Hep C	1:30,000 to 1:150,000
HIV	1:200,000 to 1:2,000,000
HTLV I & II	1:250,000 to 1:2,000,000
<b>Overall 1 in 30k to 2M, depending on which infection</b>	

“All other systems reviewed and negative, except as noted” may be used when > 10 systems reviewed”. PMH & FHx may ea ct as one system in ROS.

“Unable to fully assess d.t. AMS or pt’s condition

Physical exam incomplete due to critical condition

I. Medicare: # of dx or tx opts: 1) dx all probs or conds, 2) “Exac” worth more, 3) doc add’l w/u, 4) use cc as dx

II. Medicare: Amt &/or complex of data rev’d: 1) decision to obtain and summ of old recs, labs, rad, 2) d/w family or PMD, 3) labs and rad

III. Medicare: Risk of complics &/or M&M: 1) Meds given: IV > IM > PO

IV. Pvt ins: cc, final dx, and ED crs det lvl of visit. Points for rsrc consump. 1) 1 point = pelvic and rectal, consult, rec review, IVF, EKG, montior, O<sub>2</sub>, bcx, trop; 2) ea x-ray is a sep point

V. Crit care: must doc total time spent. Incls time spent and procs, sep bill procs (cpr, intub, transvenous PM, LP, lac repairs, chest tube). Does not have to be beside or continuous.

Swelling of tongue or lip => concern for airway

Norepinephrine	alpha > beta1 >> beta2	
Epinephrine	alpha and beta	
Dopamine	DA, alpha and beta1	
Dobutamine	beta1 > beta2=alpha	? vasodilation
Phenylephrine	phenylephrine (alpha)	no beta
Isoproterenol	only beta	vasodilation
Amrinone	PDE inhib	vasodilation

IV Drip rate:  $\text{Desired cc/min} \times \text{drop factor} = \text{gtt/min}$   
 $\geq \text{D20 reqs central line}$

**Peds: Bolus** 20cc/kg NS, x2 if necessary, then t/c colloids, blood, plasma

**Maintenance:** < 20-25 kg  $\rightarrow$  D5 $\frac{1}{4}$ NS + 20 mEq/L KCl

>25 kg  $\rightarrow$  D5 $\frac{1}{2}$ NS + 20 mEq/L KCl

**“100/50/20” Rule:** 100 cc/kg for up to the 1st 10 kg of body weight\*  
50 cc/kg for up to the 2nd 10 kg of body weight  
20 cc/kg for up to the 3rd 10 kg of body weight

Max total fluid/day usually 2-2.5L cc

**“4/2/1” Rule:** 0-10 kg: 4 mL/kg/hr  
10-20 kg: 40 mL/hr + 2 mL/kg/hr  $\times$  (wt-10 kg)  
>20 kg: 60 mL/hr + 1 mL/kg/hr  $\times$  (wt-20 kg)

DDx: at least 4, justifies ancillary tests

Order “Observation Status. Order and time, admission note, reassess note, d/c note  
“By Me”

Reduction/fx: days to f/u with ortho, I think want > 3-4, or may have been 5

Conscious sed: drug used and monitored

Splits: doc pre- and post-exam of splinted area

LP- CSF interp.

Debridement

EKG: rath, rhythm, and interp.

Rhythm EKG rept: NSR @ 68 bpm no ectopy

Doc all interprs and procs

Sit whenever possible. Demo high lvl certainty in dx & tx.

Town done voice. Let them vent. Blameless apology. “Have I done something to upset you?” Greeting & ID. Remark on pt cond, waiting time, RN assessment, offer symptom relief”. Try to estimate wait times.

When can return to nl activ. Can you tell me what your medical problem is? What are you going to do (incl for f/u)? Why is it important that you do this?

Otherwise healthy, 1<sup>st</sup>-onset sz pts w/ no comorbs & have returned to their baseline

**Level A-** none

**Level B-** serum glu, Na, preg test. If immunocompromised  $\rightarrow$  LP. Should receive CTH in ED, deferred outpt neuroimaging may be used if has reliable f/u

**Level C-** if nl neuro exam, can d/c. If nl neuro exam, no comorbs, and no structural brain dis  $\rightarrow$  no need start anti-epileptics in ED

**Sz w/ known sz d/o and subther on phenytoin:** Level C- IV or PO phenytoin or IM fosphenytoin and restart qd PO maintenance dose.

**Status epilepticus:** Level C- IV “high-dose” phenytoin, phenobarb, valproic acid, midazolam infusion, pentobarb infusion, or propofol infusion

T/c EEG in pts if suspect nonconvulsive status epilepticus or in subtle convulsive status epilepticus, pts given long-acting paralytic, or pts in drug-induced coma

Level A- high certainty

Level B- mod certainty

Level C- based on prelim, inconclusive, or conflicting evidence. Or based on consensus of ACEP’s “Clinical Policies Committee”

	<u>Levels 1-3</u>	<u>Level 4</u>	<u>Level 5</u>	<u>Crit Care</u>
	Straight Fwd	Detailed	Comprehensive	*crit car must be doc approp with at least 30 min of cumulative time spent & chk the box excluding time spent on separately billed procs
	Brief HPI	Extended HPI	Extended HPI	
HPI	1-3 HPI els	≤ 4 HPI els	≤ 4 HPI els	
ROS	1+ rel to HPI	2-9 sys or ROS caveat	10+ sys or ROS caveat	
PFSH	Not req'd	1 area (past hx)	2 areas (past hx & soc hx)	
Exam	Constitutional & rel body areas/org sys's	5-7 els req'd (body area/org sys)	8 org sys red'q	

Trich vaginalis	Malodor, itchy, profuse white or white tinged d/c (can be gray, green, or frothy). Cvx stippled or punctuate strawberry, pH > 5.5. Motile trichomonads, pear-sh w/ 3-5 flagella at one end, sl lg'er than leukocyte. Flagyl 2g PO x1 & tx partner
BV	Malodor homog gray or white d/c, +amine sniff test, clue cells. Fr overgrowth of G vaginalis, mycoplasma hominis, & mobiluncus spp, anaerobes, & other bact. Rel defic of lactobacillus. Flagyl 500 mg po bid x7d or 0.75% gel intravag bid x5d or Clinda 300 mg bid x7d
Candida	Risk abx, preg, OC's, steroids, DM, restrict clothg. Itch enough to prevent sleep. Non-odorous, sticky d/c cottage cheese texture. Vag, vulva, & perineum hyperpig, scalded. Tx Fluconazole 150 mg po x1 if not preg or many OTC antifung creams, suppositories, & tablets
Chancroid	H ducrei, azithro 1g po x1 [ceftriaxone 250 mg IM x1, erythro 500 mg po x7d]
L venereum	C trachomatis, doxy 100 mg po bid x21d [erythro 500 mg po qid x21d or SMX 500 mg po qid x21d]

