TIPS & TRICKS FROM THE ED

VICTORIA/ SOUTH ISLAND DIVISIONS OF FAMILY PRACTICE

Focused guidelines to assist FPs in making decisions about which patients should be referred to the ED.

BROUGHT TO YOU BY TRANSITIONS IN CARE ERP-FP WORKING GROUP

Victoria Division of Family Practice
An FPSC initiative

South Island Division of Family Practice
An FPSC initiative

TIP: CONCERNED A PATIENT MIGHT PRESENT WITH A NEW SERIOUS ABNORMALITY IN THE ED?

When your patient has an imaging test showing a new serious abnormality (i.e., cancer), they will be directed to the ED to have the results reviewed by the ED physician.

This often means your patient will be told about their new serious health issue by a complete stranger in a loud, rushed environment, which is not a great experience for either the patient or the ED physician.

What can you do?

Write "Patient to follow-up with FP for results" on the imaging requisition if you are concerned about a serious result in a NON-life threatening situation.

TIP: WORRIED ABOUT A PATIENT WITH NEW ONSET ATRIAL FIBRILLATION?

If you have a patient with atrial fibrillation of **unknown duration**, take a step back and ask yourself, "What can I do for them right here, right now?"

- Do a good history and physical exam
- Order a STAT ECG, CBC, serum electrolytes and Creatinine
- Start a rate controlling agent (GOAL: to get HR<100 at rest <110 walking)
- Anticoagulate until assessment for possible cardioversion can be done

TIP: Send your patient to the ED if they are UNSTABLE:

- Active ischemia (symptomatic [e.g. angina] or electrocardiographic evidence)
- Evidence of organ hypoperfusion (e.g. cold clammy skin, confusion, acute kidney injury)
- Severe manifestations of heart failure (e.g. pulmonary edema).

Everything else can be handled by you and your friendly neighbourhood cardiologists! Don't forget that the Atrial Fibrillation Clinic provides a very thorough service for patient education and management.
You are not alone!

TRICKS:

- Read the UpToDate section on New Onset of Atrial Fibrillation available through the VDFP website (an excellent resource)
- Check out this video.
- Review 2021 CAEP Acute Atrial Fibrillation/Flutter Best Practices Checklist

Tip: I hate the on-call critical INR!

Did you just get a call from the lab about a critical INR while you were heading out the door to have dinner with your family? Here's a quick guideline to get you started

Critical INRs made easy:

If there is any bleeding with an INR >3.6, your patient needs assessment at the ED.

- **INR is 5.0-9.0 WITHOUT bleeding:** No fuss! Just hold 1-2 doses then recheck INR in 2 days and decrease the weekly dose by 10-20% when the INR is therapeutic.
- **INR is >9.0 WITHOUT bleeding:** stop the warfarin, consider giving one dose of vitamin K 2.5mg orally if the patient is at high risk of bleeding, and repeat the same vitamin K dose in 24 hours if INR still greater than 9.0. Resume warfarin when INR is therapeutic and reduce weekly dose by 20%.

Some Useful Resources

1. https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/warfarinmgmt_2015_full.pdf
2. https://thrombosiscanada.ca/wp-content/uploads/2021/01/16.-Warfarin-Out-of-Range-INR_31July2020.pdf

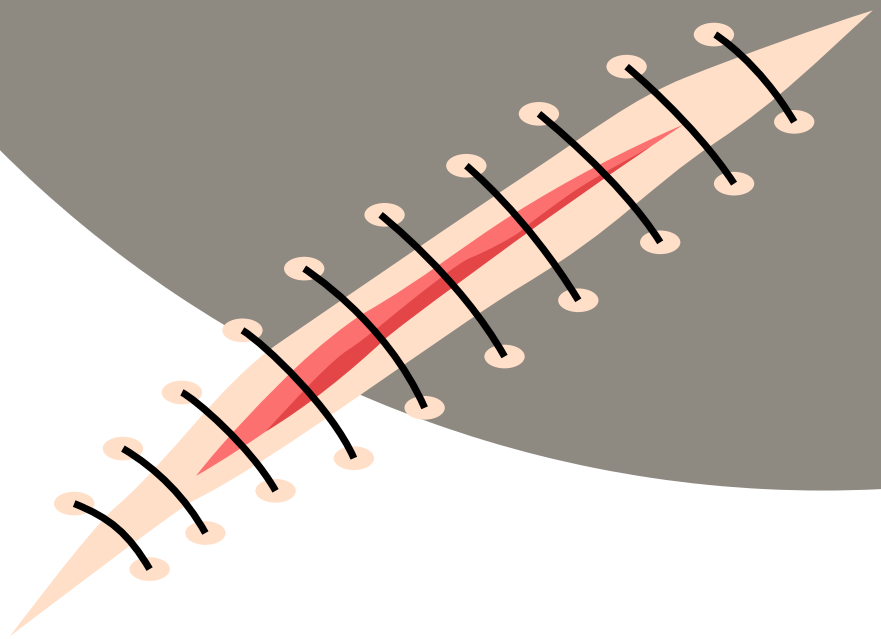
Haven't been able to find vitamin K in the community?
Try the Douglas Street Shoppers Drug Mart and order vitamin K 2.5 mg (1/4 ampule) orally.

Community family physicians can often deal with minor lacerations and minor I+Ds of infected cysts or abscesses in the office, even in children. It can throw your schedule off kilter, but it's a good chance to keep up those procedural skills!

Don't be afraid, and make use of your office staff to support you!

TIP: If you think the patient needs sedation for the procedure, keep them NPO and send them in to the ED.

TRICK: If you feel you would like to improve your skills in lacerations and I+Ds (we all get a little rusty on some things), check out St. Paul's CME courses on ED or Rural Family Practice - they often have hands-on sessions dedicated to improving procedural skills.

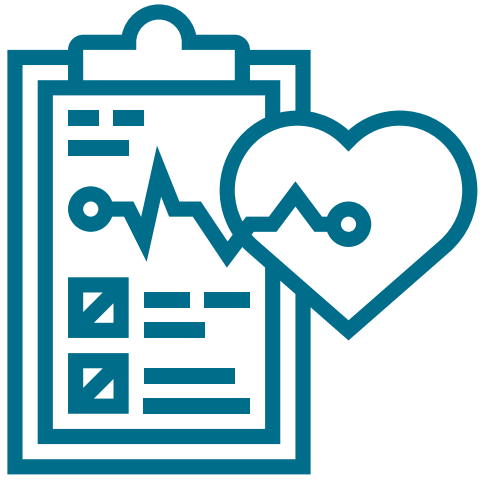


Tip: Be Brave and Do Office Procedures!

TIP: THINK YOUR PATIENT NEEDS TO BE SENT TO THE ED?

Ever had a situation where your day is packed and someone in the waiting room is REALLY sick?

Your full assessment, including vitals and physical findings, is valuable - it helps the patient know they are being cared for and is very helpful for the ED doc.



TIP: Put your diagnosis on the referral form to help the ERP know what you're thinking.

TRICK: If you already know the diagnosis and think they need a specialist, contact the on-call specialist directly (through the switchboard) to avoid a lengthy wait in the ED.

Tip: Help! I have a pregnant patient who is bleeding.... *part 1*

For those who don't practice obstetrical medicine, seeing a patient with a first trimester bleed can be stressful and perplexing. Sometimes, the ED is just the right place for them to go, but often FPs can safely manage the initial evaluation. This is especially important to patients at an often emotional time.

- **Remember 5-10 weeks GA is the critical point for ectopic pregnancy. Severe pain and bleeding = ED!**
- **For bleeding AFTER the first trimester in ANY patient, call Gynecology on call and send the patient to the hospital for urgent ultrasound and assessment.**

If the patient is in their first trimester and has light or moderate bleeding with cramping similar to a period:

- Order a CBC, Rh factor and serial quantitative b-hCG. As well as a pelvic US, to confirm intrauterine pregnancy, regardless of b-hCG.
- TransVAGINAL pelvic ultrasound can be done through Medical Imaging OR the Vancouver Island Women's Clinic within 24-48 hours - as early as 4.5 weeks GA (when the bHCG >1500 mIU/mL).
- TransABDOMINAL ultrasound is often sufficient for b-hCG >6500 mIU/mL.

Tip: Help! I have a pregnant patient who is bleeding.... *part 2*

TRICK: During regular office hours, the Vancouver Island Women's Clinic takes referrals to evaluate, monitor and manage miscarriages. They usually see patients within 1-2 days of your call.

Clinic phone number: 250 480 7377
On Call doctor: 778 265 4111

Who to send to the ED?

- The patient is having heavy bleeding (changing a pad every 30-60 minutes for more than 3 hours)
- There is severe pain/cramping
- The patient experiences presyncope/syncope

- **TIP: You really need the ultrasound for dates to properly evaluate bHCG.** A serial bHCG that does not rise by at least 50% after 48 hours is concerning prior to 8-9 weeks GA, when the levels can plateau and slightly decrease.
- **TIP: Rh factor should be done at the HOSPITAL lab**, as Life Labs results can take up to a week. RHIG (WinRHO) should be administered within 72 hours through the Vancouver Island Women's Clinic, the VGH CFAU, or the ED if required.

What about On Call? *If you get a call from a patient after hours, this workup can be arranged for the following day when you are back in the office, with instructions to go to the ED if things worsen*

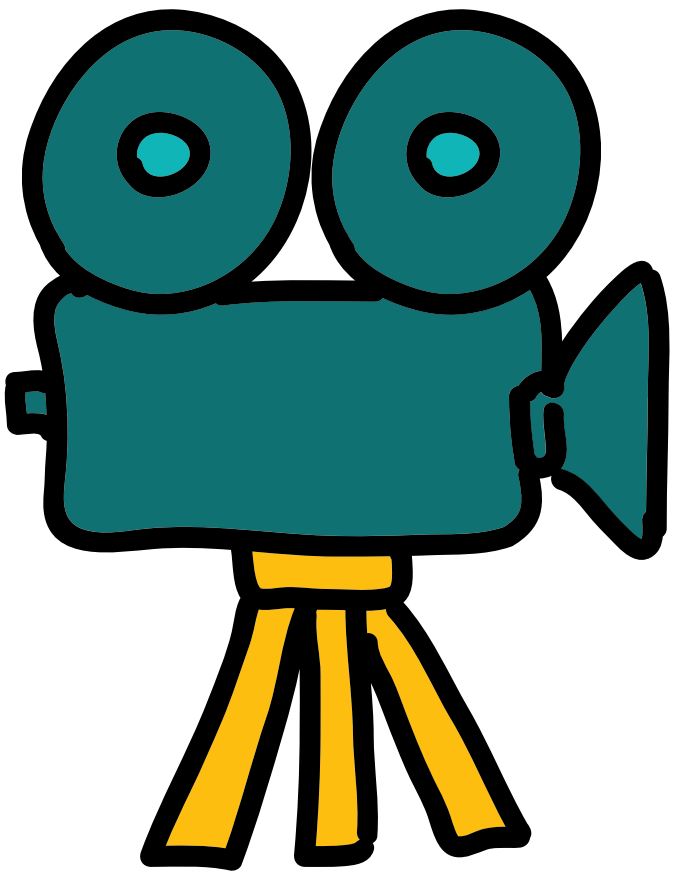
Check out this **helpful resource**: https://www.bcemergencynetwork.ca/clinical_resource/1st-trimester-bleeding-miscarriage-diagnosis/

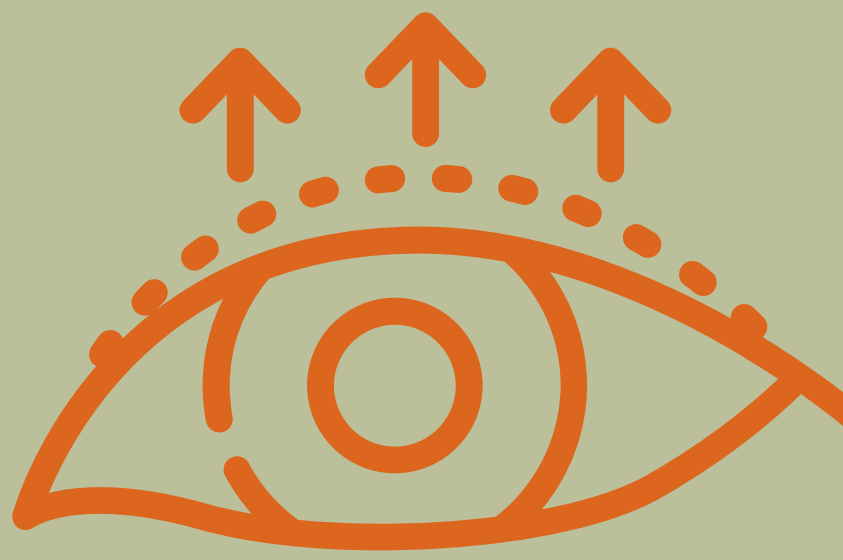
TIP: Everting the Eyelid

We've all had the awkward and frustrating experience of trying to look UNDER someone's eyelid. There are several available techniques - grab the eyelashes, flip the lid over a Q-tip/stick, etc. - with varying degrees of success.

Check out this minute long video on lid eversion techniques created by UBC Medicine:

https://www.youtube.com/watch?v=UDMaT9s0ZnA





TIP: THE NOSE BLOWS

True story: Our main boat motor had broken down so we had to putt along for 4.5 hours on our little motor with a nine and six year old squeezed somewhere in between a week's worth of gear. At the fairly squirrelly four-hour mark, I looked over at our six-year-old son, who was silently grinning from ear to ear with two brown almonds just barely protruding from his nostrils....

It remains a mystery WHY kids put things in their nose, but it is no longer a mystery how to get it out! Check out this family-involved technique for removing a foreign body from a child's nose using a parent's "kiss." It works about 60% of the time, but should always be done under medical supervision due to the risk of aspiration (as with any removal of foreign body) and the theoretical risk of barotrauma to the ears and lungs.

How to perform the 'parent's kiss':

1. The procedure should be fully explained to the parent (or other trusted adult) and the child told they will be given a 'big kiss.'
2. Instruct parent to place their mouth over the child's open mouth, forming a firm seal as if performing mouth-to-mouth resuscitation
3. Next, occlude the unaffected nostril with a finger
4. The adult blows until they feel resistance caused by the closure of the child's glottis.
5. Finally, give a sharp exhalation to deliver a short puff of air into the child's mouth (which passes through the nasopharynx and out through the unoccluded nostril)
6. If necessary, the procedure can be repeated a number of times

TRICK: If the parent cannot perform the procedure, you can perform the same process with a bag-valve-mask. Ensure the mask covers only the childs' mouth.

RESOURCES:

See www.racgp.org.au/afp/2013/may/mothers-kiss/ for more information.
Paren't kiss video. Bag-valve-mask video

Tip: Quick relief from nausea using a packet from your pocket

Who knew the ubiquitous alcohol swab could help nauseous patients feel better! How easy is it? Sit your patient down with an emesis tray at the ready. Have the patient do three nasal inhalations (in through the nose - out through the mouth) from an opened alcohol swab every 15 minutes, with 2 repeats if necessary.

Want more info? Check out:
www.aliem.com/2015/trick-trade-isopropyl-alcohol-vapor-inhalation-nausea-vomiting/

The use of inhaled isopropyl alcohol has been well-studied in anesthesia literature showing at least a 50% decrease in the severity of nausea within 10 minutes, which is 20 minutes faster than IV ondansetron! Even a 2012 Cochrane Review concluded that isopropyl alcohol was effective in reducing the need for rescue anti-emetics; but it is NOT RECOMMENDED IN CHILDREN as it just too noxiously stinky for kids. With no reported adverse reactions in adults, this inhaled vapor is extremely cheap and readily available.

Tip: Head Injuries in Children 0-18yrs

Head injuries in children have to be one of the most upsetting situations for parents and caregivers; making assessment, accurate treatment and giving appropriate instructions for observation extremely important.

GCS following head injury is typically the parameter used to assess severity. A child presenting with GCS under 13 or declining GSC should be sent to the ED and will likely undergo further work up with imaging. For a child with GCS 14 or 15, providers must use clinical reasoning to decide whether the risk of radiation from CT head outweighs the risk they of developing a significant traumatic brain injury.

It should be noted that children under the age of 2 are assessed on different parameters given differences in presentation, anatomy/physiology etc.

What defines **minor head trauma**?

If <2 years old

- History of blunt trauma in infants who are alert or awaken to voice or light touch

If >2 years old

- GCS of 14 or 15 on initial exam
- No abnormal or focal findings on neurological exam
- No evidence of skull #

Patients with **minor head trauma** who meet all of the following criteria may resume **normal activity**:

- Age >3 months
- Normal mental status and at a baseline level of function
- Low-risk mechanism of injury
- No concern for inflicted injury
- No loss of consciousness or seizure
- No other apparent injuries
- No vomiting or only one episode of vomiting occurring shortly after injury
- No significant headache
- For the infants 3 to 12 months of age, trivial injury with either no hematoma or a small frontal scalp hematoma
- No underlying conditions predisposing to clinically important traumatic brain injury
- Reliable caretakers who are able to seek care, if indicated (UpToDate)

...

Tip continued...

If you have classified your patient as having a minor head injury, you must now decide whether they can be safely discharged, require further observation or should be sent to the ED for a CT head and possible intervention.

There are 3 clinical decision making tools with different sets of criteria that can aid in that decision making:

PECARN

PECARN Pediatric Head Injury/Trauma Algorithm
mdcalc.com

CATCH

CATCH (Canadian Assessment of Tomography for Childhood Head injury) Rule
mdcalc.com

CHALICE

CHALICE (Children's Head injury ALgorithm for the prediction of Important...
mdcalc.com

The PECARN rule was tested to have the highest sensitivity (100%) and the CHALICE rule with the highest specificity (85%), therefore encouraging PECARN to be incorporated into practice to limit missing significant TBIs.

Based off the decision tool and combined clinical gestalt, if the recommendation is no imaging or observation, the following resources are recommended for caretakers

- BCCH Head Injury Advise for Parents and Caretakers: http://www.bcchildrens.ca/Resource-Centre-site/Documents/D-E/BCCH1001_HeadInjury_2014.pdf
- A concussion guide for parents and caregivers: https://parachute.ca/wp-content/uploads/2019/06/Concussion-Guide-for-Parents-and-Caregivers.pdf
- Parachute Canada's information on concussions: https://parachute.ca/en/injury-topic/concussion/
- From YouTube: From Dr. Mike Evans - Concussion Management What they are and what they do: https://www.youtube.com/watch?v=_55YmblG9YM
- From YouTube: From Dr. Mike Evans - Concussions 101 a Primer for Kids and Parents: https://www.youtube.com/watch?v=zCCD52Pty4A

TIP: COUGH, BARK, AND WHEEZE IN KIDS

'Tis the season of the ABCs - Asthma, Bronchiolitis and Croup

Our ED colleagues have shared a GREAT Canadian website for assessment and treatment of paediatric medical conditions: **www.trekk.ca**. You don't need to log in – just type and search for great, concise recommendations.

Here are a few highlights from the Trekk website:

TIP: For kids with a moderate ASTHMA exacerbation, consider adding a single dose of oral dexamethasone (0.15-0.6 mg/kg) to their inhaled regimen. This has been shown to significantly decrease respiratory distress within 2-6 hours and decrease admissions to hospital. (Link to a scoring tool for mild-moderate-severe also on the website).

TIP: BRONCHIOLITIS most commonly hits your really young patients - mostly under age two, but especially under 12 months. If you have a child less than 12 months old, with a first episode of wheeze in the winter months, it's likely bronchiolitis and should NOT be treated with Ventolin, Atrovent, inhaled steroids, antibiotics, hypertonic saline or systemic corticosteroids. SUPPORT a to ensure adequate oxygenation and hydration is the main treatments.

TIP: For that youngster with acute onset of barky cough, CROUP is the likely cause. New recommendations state that ALL kids with croup should have a single dose of oral dexamethasone at 0.15-0.6 mg/kg (max 12 mg). Nebulized epinephrine is only required if stridor, mod-severe increased work of breathing, or agitation. Red flag features: drooling, significant pain, low O2 sat, outside normal age range, not improving with treatment.

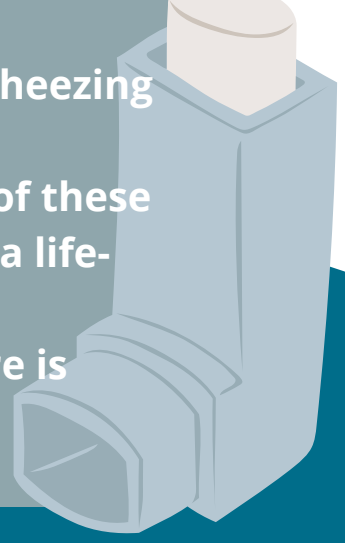
TIP: RADIAL HEAD DISLOCATION IN CHILDREN

Tip: Do you have a young child in your clinic who does not seem to want to use their arm after a pulling injury? Maybe they were with a caregiver who grabbed the child's hand to prevent them from falling or maybe they were playing with a parent who was swinging the child. They might have a radial head subluxation (A.K.A. “nursemaids elbow”)

Trick: If the accident was non-traumatic and there is no neurovascular compromise, bony pain, or edema, you might have all the tools you need to get the little one back on with their day! In a radial head subluxation, some of the annular ligament is displaced into the radio-humeral joint space. Scan this QR code on your phone to watch this quick video for an example of how to quickly and easily reduce the dislocation:

https://www.youtube.com/watch?v=n74j7dNQbjU&ab_channel=LarryMellick

An asthmatic comes to your office wheezing and struggling to breath!
Yes, the ED is the best place for one of these patients who may be suffering from a life-threatening asthma attack.
While you wait for EMS to arrive, here is what you should do:



TIP

1. Transport from office to the ED via ambulance should be considered for severe exacerbations marked by a patient with one or more of the following; breathlessness at rest, drowsiness, inability to speak in full sentences, RR >30, HR >120, SpO2 <90 %
2. While the patient in awaiting transport:
    a. Administer SABA (Ventolin/Salbutamol) 4-6 puffs via MDI with spacer (or albuterol 2.5 mg/3 mL nebulized) every 20 minutes for the first hour.
    b. Most patients suffering from a significant exacerbation should be administered systemic glucocorticoids- Prednisone 40-60mg orally (continued for 5-7 days) OR Dexamethasone 12-16 mg daily for 1-2 days.
    c. Administer supplemental oxygen to maintain SpO2 >92%
3. When do you consider your patient to be getting better and eligible to be considered for disposition home? Symptoms decreased, vitals stabilized (normal HR, RR and SpO2 >94% RA) with PEF >70% of predicted or personal best.
    - Advise to complete 5-7 day Prednisone course
    - Advise to use SABA as needed (which may be q3-4 hours for the first 48 hours)
    - Consider increasing controller medication by 1 step if not already on maximal GC/LABA
    - Review the patient's asthma action plan and re-iterate correct inhaler techniques and avoidance of triggers
    - Schedule patient for follow up in 1-week (or less if sent to the ED).

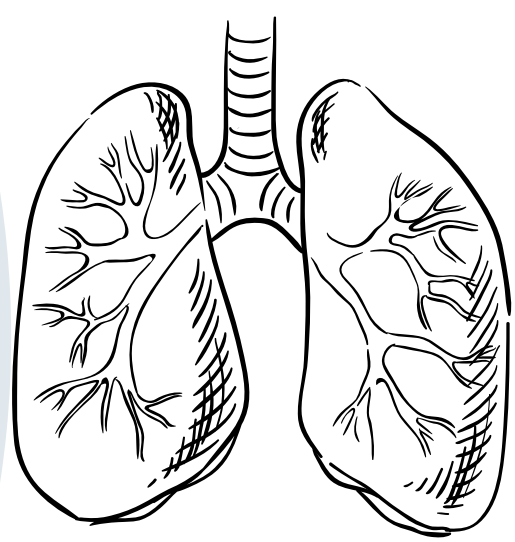
Tip: The Wheezing Asthmatic

TRICK

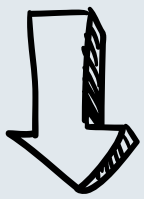
Long before any asthma patient arrives at your office experiencing respiratory difficulties, it is important to take stock of what you have on hand to rapidly relieve their symptoms. Be sure to have Ventolin with a chamber, oral corticosteroids and controlled oxygen (tubing and nasal prongs) in the office. It is much better to have them at the ready and never need them than to NOT have them when your patient with asthma arrives in distress!

Printed instructions for all types of inhalers are found on the asthma.ca website: https://asthma.ca/get-help/treatment/how-to-use/

Signed up for Pathways? Inhaler education videos are available on https://pathwaysbc.ca/ under Resources -> Patient Information -> Respiratory. You can email the videos directly to your patient from the Pathways website



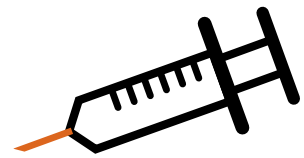
Looking for other Personal/Patient Resources?



- From Asthma.ca Medicines and Treatment: https://asthma.ca/get-help/treatment/
- From Asthma.ca Resource (pdf) for Medications- Use as prescribed: https://asthma.ca/wp-content/uploads/2020/06/BreatheEasy_Medications-Final-2022-EN.pdf
- From Pathways for Physicians: Asthma Inhaled Medication Table Update: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/provincial-academic-detailing-service/pad-refills/padrefillsasthmadec2020.pdf
- From Pathways for Physicians: Child Health BC Provincial Asthma Guideline Pediatric Asthma Education Checklist : https://pathwaysbc-production-content-item-documents.s3.amazonaws.com/documents/4120/original/CHBC_Provincial_Asthma_Guideline_Education_Checklist_May_2018.pdf?1586895249

Tip continued ...

TIP: ANAPHYLAXIS



Your MOA has just fit in an 8-year-old patient and her parents, stating that the child appears anxious with very swollen lips and eyes. When you see her, you note wheals and redness on her neck and chest. You are certain she is having an allergic reaction and are now on high alert for anaphylaxis. She complains that her tongue feels tingly and she is having some difficulty breathing.

TIP: Prepare Ahead!
This is when you jump into action and quickly grab the emergency kit you have prepared for events just like this. Ask your MOA to call 911.

- Remove allergic trigger if present
- Place patient supine (unless vomiting). Don't let patient walk or stand
- With your airway support equipment at the ready, give epinephrine 0.15 mg (for kids up to 20kg/44 lbs) intramuscularly into the thigh. Dosing for kids over 20kg and adults is 0.3 mg IM; consider smaller dosing for frail elderly or high CV risk patients. Watch for signs of improvement and redose in 5 minutes if worsening.

TRICK: You did it!
While your patient is improving and you are waiting for the ambulance to arrive to transfer your patient to the ED for observation, prepare and discuss a prescription for 2 EpiPens to have available for immediate use if this situation occurs again. It's a good idea to have a practice kit in your office to let patients see and feel how to use it. **Free kits** are easily ordered at: https://www.epipen.ca/order-your-free-epipen-essential

Book a follow-up appointment to review the proper use of the EpiPen and explore what allergen may have precipitated this event.

Here is a video demonstration that will help you teach your patient and her parents how to use an EpiPen: https://www.youtube.com/watch?v=uBvdO9a9NTQ&t=19s

Tip :

Infectious Diseases and the Outpatient Antimicrobial Therapy Clinic

Do you have a patient who is 15 years of age or older, needs once daily IV antibiotics but is <u>not</u> requiring hospitalization? The OPAT clinic might be the perfect spot for them!

Does the patient need to be seen TODAY (which may mean a first dose through the ED if outside clinic hours) or can they wait until the next morning to be assessed at the OPAT clinic?

OPAT is also the contact point for outpatients who may be eligible for home IV therapy. This program provides assessment, education, and support for patients undergoing intravenous therapy who could recover at home.

1. CALL the Hospital Switchboard (250-370-8000) and ask for Infectious Disease at the OPAT clinic between 7:30 and 1:00pm or ask for the on-call ID outside of those hours. **ID has asked that physicians call the clinic first to discuss the patient, before sending in a referral.**

2. After discussing your patient with the ID physician, you can send a referral letter by fax to 250-370-8638.

The clinic is open seven days a week from 7:30 am-1:00 pm; however, new referrals are not taken on weekends or statutory holidays. Patients need to arrive at the clinic at 7:30 am for their first appointment but subsequently are given scheduled appointment times.

Tip: Using **Pathways** to Easily Find Outpatient Clinics

Frazzled and frustrated trying to figure out which specialties have clinics you can refer your patients to? It's hard to remember which services have to be arranged through an inpatient MRP and which community FPs can refer to regardless of what privileges they hold.

Well, good news! The Victoria Division's Pathways site lists over 20 outpatient clinics that you can refer to directly. All you have to do is log on to Pathways and search the word "outpatient". Easy!
Clinics include:

- Pain Management (RJH)
- Atrial Fibrillation (VGH)
- Cardiac Rehabilitation (RJH)
- Heart Function (RJH)
- Gestational Diabetes (VGH)
- Flexible Sigmoidoscopy (RJH)
- Seniors Outpatient Clinic (SOPC)
- Pressure Injury Access (RJH)
- Lower Leg Wound (FLUC, RJH)
- Outpatient Antimicrobial Therapy (OPAT, RJH)
- Anticoagulation Therapy (ATC)
- Medical Daycare (RJH)
- Urgent Medical Assessment (UMAC)
- Neuro-Rehabilitation/ Rehab Medicine (VGH)
- Stroke Rapid Assessment Unit (SRAU)
- Colposcopy (RJH)
- Cutaneous Surgery (RJH)
- Urgent Vascular Limb (RJH)
- Pulmonary Function Lab (RJH)
- Respiratory Education Centre (RJH)
- Warfarin Initiation (RJH)
- Seniors (SOPC)
- Eating Disorders Program (Kelty)
- TB Prevention and Control (RJH)
- Covid-19 Therapeutics
- Transplant (RJH)
- Acute nephrology (RJH)
- Addictions Treatment
- Anscomb Child and Youth Treatment for Significant psychiatric symptoms
- Adolescent psychiatric Services
- Treatment for Mental Health
- Detox/Withdrawal
- IV Iron Infusions

- Trick: You can also find these clinics by searching for a specialty under the 'Select Specialty of Service' (e.g. find the Pulmonary Function Lab under Respirology).

- Tip: Pathways contains information about clinics that are physician-led. Allied health clinics, such as the Tall Tree Concussion Program, are not included (for more information on that program and to access their resources, you can visit their website at concussion.talltreehealth.ca/doctors).

So how do you access Pathways? If you don't already have a log in, you can contact Cherith Golightly at victoria@pathwaysbc.ca. She will get you set up!

Physician Connectors (250-519-5282) is another great resource that provides a single point of access for FPs to help patients get connected with Island Health programs and community health programs and services.

TIP: ACCESS TO MEDICAL IMAGING

Truth, or myth? "ED Physicians can get any imaging studies done sooner than physicians outside the ED."

Myth!

The TRUTH is that aside from truly life-threatening situations (ask yourself: Is my patient going to DIE TODAY if I don't get this imaging done?), ED physicians have the same access to X-rays, ultrasounds, CTs and MRIs that community physicians have.

TIP: DON'T send patients to the ED to "get your imaging test done more quickly," because all it will give your patient is a very long wait ending in frustration and distrust.

TRICK: SAME-DAY CT is available for life-threatening conditions without sending your patient to the ED. Fill out a regular CT requisition, give it to your patient, and make sure they arrive at the hospital before 3pm - they will be slotted in when a spot is available.

TIP: THE PAINFUL SUBUNGAL HEMATOMA

Ouch! A patient presents to your clinic with a sore, throbbing finger due to a subungual hematoma after slamming it in the car door this morning.

TIP: If the patient has intact nail folds and the injury occurred in the past 48 hours all you need is an 18-gauge needle and 5 minutes to have that patient feeling a whole lot better!

TRICK: The trick to relieving painful pressure caused by the subungual hematoma is to make a small hole in the nail to allow blood to escape. This is called **nail trephination.** To create the hole twist a large bore needle with gentle pressure into the nail above the lunula. You will know that you are in the right spot when blood begins to escape and the patient feels some relief. Typically a digital block is not required for this procedure.

- Don't forget to consider if tetanus prophylaxis is required for this injury.
- If you are concerned about a possible fracture order an x-ray as prophylactic antibiotics may be required.

For more info see these useful sites:

1. BC Emergency Network: https://www.bcemergencynetwork.ca/clinical_resource/subungual-hematoma-treatment/
2. https://canadiem.org/subungual-hematomas-and-trephination/

TIP: EPISTAXIS

Nosebleeds can be scary for patients... Fortunately they are usually not serious and with the right care most will stop on their own.

TIP: <u>How to manage an active nosebleed:</u>

1. Assess ABCs. If unstable seek immediate emergency care and urgent ENT consult.
2. If stable, attempt conservative measures:
    a. Have patient clear clots by gently blowing nose
    b. Have them lean forward
    c. Next, they should pinch the cartilaginous portion of their nose for 20 mins x 2
    d. If ongoing bleeding after 2nd attempt perform rhinoscopy to identify the source (90% are anterior -- little's area)
    e. Anterior bleed likely? Consider cautery or nasal packing
    f. Posterior bleed likely? Send to ED for urgent ENT consult.

TRICK: The pressure applied when pinching the cartilaginous portion of nose should be hard enough to blanch the patient's fingernails. Ensure patient does not release pressure as this disrupts the clot and prevents hemostasis.

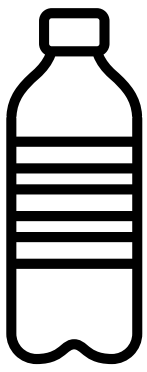
TIP: PEDIATRIC HYDRATION

You have just seen a young patient with frequent vomiting and diarrhea and you suspect they may be dehydrated.

<u>Approach to Pediatric Dehydration and Fluid Replacement:</u>

FIRST THINGS FIRST

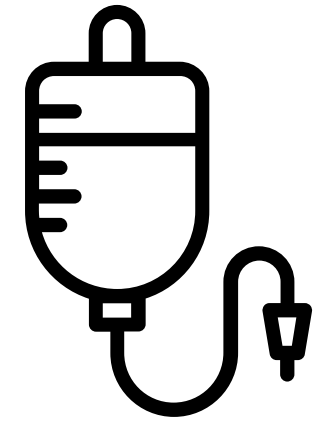
Perform physical exam to determine degree of dehydration.



Clinical Signs of Dehydration			
<u>Degree of Dehydration</u> Infant/Young Child <2yr Older Child/Adoles >2yr	<u>Mild</u> 5% 3%	<u>Moderate</u> 10% 6%	<u>Severe</u> ≥15% ≥ 9%
Heart Rate	Normal	Rapid	Rapid
Blood Pressure	Normal	Normal	Decreased
Urine Output	Mildly Decreased	Markedly Decreased	Anuria
Mucous Membranes	Moist	Tacky	Dry
Anterior Fontanelles	Normal	Sunken	Markedly Sunken
Eyes	Normal	Sunken	Markedly Sunken
Skin Turgor	Normal	Decreased	Tenting
Capillary refill	Normal (<3s)	Normal to Increased	Increased (>3s)

TIP: PEDIATRIC HYDRATION CONTINUED…

NEXT STEP Management of Dehydration



Management of Dehydration (Not intended for infants <28 days old)	
Mild and Moderate	ORAL REHYDRATION ➢ Fluids: Oral rehydration solutions (ie. Pedialyte) or dilute juice. Give at 50mL/kg over 4h + replace ongoing losses ➢ Age-appropriate diet after rehydration ➢ Children ≥ 6 months can be given 0.15mg/kg dose (max 8mg) of Ondansetron – reduces failure of ORT and need for IV fluids ➢ If ineffective → IV hydration
Severe	IV HYDRATION ➢ Send to the ED for IV fluids and close monitoring

Want to more resources?

Check out the UpToDate article on Treatment of Hypovolemia (Dehydration) in Children.

For a quick summary check out PedsCases Notes on Dehydration and Fluid Replacement.

Tip: Supporting a Patient in Situational Crisis

If you are concerned that a patient's mental illness puts their safety or the safety of others in immediate danger, call 9-1-1 and have the patient transported to the ED.

Tip: Consider if a referral to Urgent Short-Term Assessment and Treatment (USTAT) might be a good option to get support for your patient.

Trick: USTAT Provides short-term psychotherapy for patients in crisis, at risk, or in severe distress. A team of psychiatrists is available as needed for consultation and follow-up. Access is through MHSU Intake. While awaiting an appointment make sure the patient has access to Vancouver Island's Crisis Line - see below.

If you have a specific question in regard to treatment options consider contacting the **Rapid Access to Consultative Services (RACE)** line to speak with a psychiatrist . Check out: https://divisionsbc.ca/south-island/race/about-race

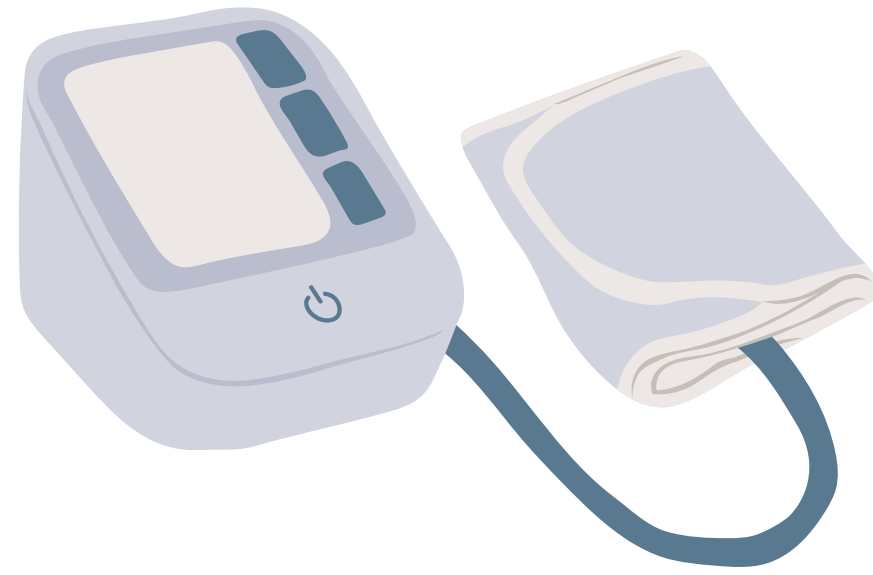
Patient Resources :

1. **24-Hour Vancouver Island Crisis Line (1-888-494-3888):** Provides supportive listening for those in emotional distress and connection to emergency mental health services when needed
2. **Wellness Together Canada:** A resource from the government of Canada with access to immediate virtual support and resources for those suffering from anxiety or depression: https://www.wellnesstogether.ca/en-CA
3. **1-800-SUICIDE (1-800-784-2433):** provincial 24/7 line to support callers with suicidal thoughts

Tip: What to do with your asymptomatic patient who has VERY high blood pressure

Hypertensive Emergency is when an acute elevation in blood pressure (>180/120) causes target organ damage. These patients should be sent to the ED immediately for management. S+S that may signify acute target organ damage include: generalized neurologic symptoms (agitation, delirium, visual r), focal neurologic symptoms, flame hemorrhages, cotton wool spots, papilledema, nausea or vomiting, chest pain or discomfort, severe back pain, or acute dyspnea.

Hypertensive Urgency or **Severe Asymptomatic Hypertension**, often associated with a mild headache in office, is much more common.



TIP! In the absence of symptoms, there is no proven benefit from rapid lowering of blood pressure.

Those with imminent cardiovascular risks from known aortic or intracranial aneurysms should be considered for BP reduction over a period of hours and should be sent to the ED.

The reduction goal for these patients should be to **<160/<100** without reducing the MAP greater than 25% over a matter of hours.

TRICK!

What steps should be taken?

1. Repeat measurement after having allowed the patient to rest in a quiet room for 30 min. If ineffective consider antihypertensives.
2. Patients with previously treated HTN?
    a. Reinstitute medications if non-adherent
    b. Consider increasing dose of current antihypertensive(s)
    c. Addition of a diuretic with consideration of the patient's renal function.
3. Patients with untreated HTN should be initiated on an anti-hypertensive most favourable for any underlying conditions, such as a CCB, BB, ACEi, or an ARB.

Check out the BC Emergency Medicine Network's Clinical Summary on the topic:
https://www.bcemergencynetwork.ca/clinical_resource/hypertensive-emergencies/

Refer to the UpToDate page on Management of Severe Asymptomatic Hypertension (see Table 2 for tx of HTN by underlying disease):
https://www.uptodate.com/contents/management-of-severe-asymptomatic-hypertension-hypertensive-urgencies-in-adults?search=hypertensive%20urgency&source=search_result&selectedTitle=1~33&usage_type=default&display_rank=1