EMERGENCY PHYSICIAN COVERAGE OF IN-HOSPITAL CODES

To the Editor:

We read the recent article “Quantifying Off-hour Emergency Physician Coverage of In-hospital Codes: A Survey of Community Emergency Departments” by Sherwin et al., and would like to comment on this important issue (1). Although Emergency Physicians (EPs) are able to adapt to exigent circumstances and typically want to help any patient in need of emergency care, it should be a rare situation and not the expected rule for EPs to leave their Emergency Department (ED) duties to provide inpatient care. Both the American Academy of Emergency Medicine and the American College of Emergency Physicians have position statements and policies that support the concept that the EP has a primary responsibility to the patients in the ED (and those patients that will soon be in the ED) and should not be required to leave the ED to provide care anywhere else in the hospital. Furthermore, it is inherent on the hospital administration and medical staff organization to ensure that proper medical coverage of emergency situations occurring outside of the ED is not dependent on the EP. Please refer to the full statements that can be found on the organizations’ websites (2–5). We support these statements and believe that they are intended to provide optimal care for all patients, in the ED as well as inside the hospital wards and intensive care units.

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TETANUS AFTER HOME PIERCING

To the Editor:

A 21-year-old man with past medical history of anxiety and pulmonary embolism approximately 3 years before arrival, presented to the Emergency Department (ED) for trismus. Two weeks before arrival, the patient purchased a piercing needle and stud at a local piercing shop. The patient believed the items were sterilized before purchase. Upon arriving home, he pierced his right lower lip. Approximately 1 week later the patient noticed yellow, purulent drainage from the piercing site. Increasing redness was also noted. Three days before the ED visit, he removed the piercing with a pair of pliers. Approximately 24 h before the ED visit, the patient felt that his “jaw locked.” He reported pain from right temple to neck and had “shaking” of his limbs. The patient denied chills, but reported subjective fevers and diaphoresis. He could not recall his last tetanus booster, but did report that he had received pediatric immunizations.

Upon presentation to a community ED, the patient received 500 units of tetanus immunoglobulin and was transferred to our academic facility for further treatment. Upon arrival at our hospital, the patient complained of headache and still being unable to open his jaw. Examination was notable for a piercing slit on the right lower lip, with erythema but no drainage. He was unable to open his
mouth more than 3–4 cm. The right masseter muscle was contracted and tender to palpation. The right sternocleidomastoid muscle was also tender to palpation. Vital signs included: temperature 36.8°C, heart rate 59 beats/min, respiratory rate 18 breaths/min, blood pressure 130/80 mm Hg, and oxygen saturation 97% on room air. Laboratory values were notable for white blood cell count 11.9 with 78% neutrophils, and hemoglobin 14.9. Electrolytes were unremarkable. Two blood culture bottles were negative for growth. Tetanus titer or antibody levels were not checked.

Upon arrival, the patient received an additional 6000 units of tetanus immunoglobulin as well as the first dose of tetanus toxoid vaccine series. Broad-spectrum antibiotics (metronidazole, vancomycin, cefepime) were started. A computed tomography (CT) scan performed to rule out deep space neck infection was negative. After CT results, the vancomycin and cefepime were stopped. The patient continued to improve, and on day of discharge, 2 days later, was able to open his mouth and only complained of right masseter tenderness. He was discharged on metronidazole 500 mg four times a day as treatment for the cellulitis, and a diazepam taper for muscle spasticity and stiffness.

Reports describing the risks and complications associated with body piercing are limited in the medical literature. One of the earliest collections of case reports dates from 1894, when Thorner described a child dying from trismus after ear piercing (1). A case report from Sweden in 2005 describes both a 39-year-old man who developed Fournier gangrene from a genital piercing, and a young woman who developed mastitis from breast piercings (2). In 1998, O’Malley et al. reported a case of a 27-year-old woman who self-pierced her belly button. Ten days later she presented to an ED with facial pain and trismus. After immunoglobulin treatment she improved. Similar to the above patient, she did not require mechanical ventilation. It was felt that her antibody levels prevented her from developing a severe form of the disease (3). Because anti-toxin blood levels were not obtained in my patient, one can only presume the same.

This case illustrates that, despite being a rare occurrence, tetany is still seen in this country and must be considered as a diagnosis. This is especially true in the subgroup of patients involved in home piercing. Tetanus immune globulin (TIG) is the recommended treatment. TIG will bind to unbound toxin but will not affect toxin already bound to nerve endings. A single intramuscular dose of 3000–5000 units is recommended for adults and children. The World Health Organization (WHO) recommends TIG 500 units be administered as soon as possible. If infection is suspected, broad-spectrum antibiotics should be initiated. The WHO also recommends metronidazole as the preferred antibiotic (4).

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□ HIGH-PRESSURE AIR INJECTION INJURY TO THE UPPER EXTREMITY

To the Editor:

High-pressure air is used in industrial cleaning and cutting. High-pressure injection injuries are not commonly seen in the Emergency Department (ED). High-pressure air injection injuries are different from injection injuries caused by other agents, in that they are associated with extensive subcutaneous emphysema but only slight soft tissue inflammation or destruction.

A 28-year-old right-handed woman who was a worker in a local industrial cleaning company was brought to the ED 40 min after sustaining an injury to her left hand from the high-pressure air blaster she was operating. Her vital signs were as follows: blood pressure 125/75 mm Hg, pulse rate 96 beats/min, respiratory rate 18 breaths/min, axillary temperature 37°C, and SpO2 98% by pulse oximeter on room air. She had no past medical history or medication. On arrival in the ED, she complained of severe pain in the hand and forearm, exacerbated by any active movement. She had 1-cm entry marks on the left hand fifth proximal phalanx (Figure 1). There was circumferential edema of the fourth and fifth digits extending proximally to the thenar and hypothenar eminence of the palm. Radial, ulnar, and brachial pulses were palpable. Physical examination of the hand was performed. Sensory function of the radial, ulnar, and median nerves was intact. Motor function was present, but she experienced severe arm and forearm pain on active and passive flexion of the elbow and on flexion and extension of the wrist. The range of movement was restricted.