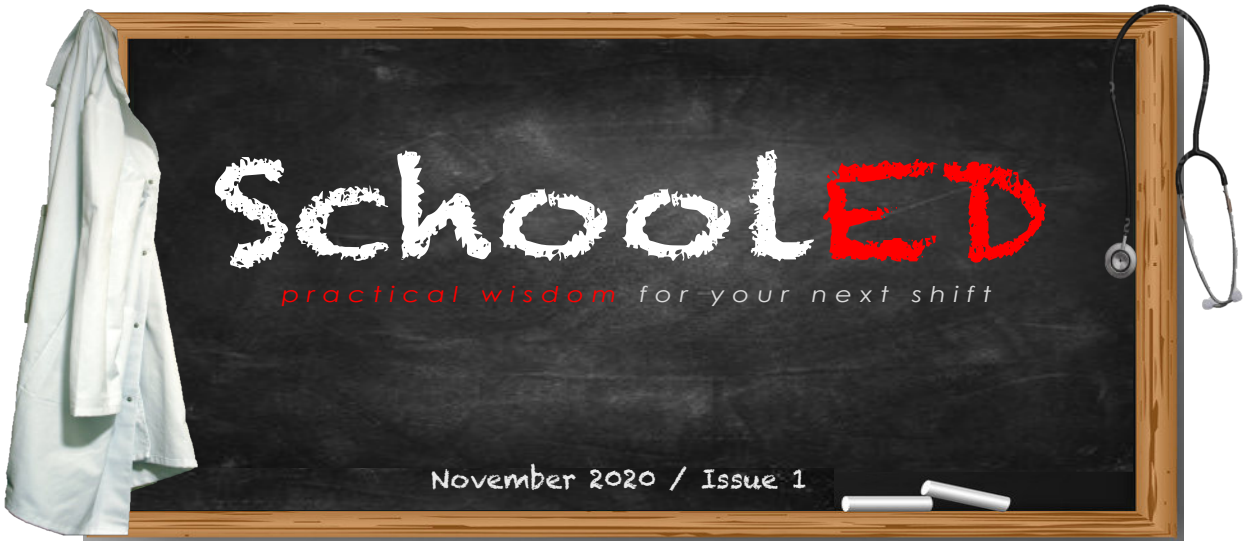

Acute Upper GI Bleeding

–By Jessica Downing, MD and Stephanie Cardona, DO

Although mortality associated with many forms of upper GI bleeding, such as peptic ulcer disease and malignancy is decreasing, however, the mortality rate associated with variceal bleeds has remained constant. While the underlying cause of an upper GI bleed may be suspected based on history and physical exam, endoscopy is often required to confirm the diagnosis. For this reason, we are often forced to manage upper GI bleeds in the Emergency Departments based on differentials, rather than confirmed diagnoses.

The Stable GI Bleeder

MEDICATIONS

All patients with upper GI bleeding should be given loading dose IV proton pump inhibitor (PPI), e.g. 80mg of Protonix. If the patient has known or suspected liver disease, give an Octreotide bolus of 50 mcg, followed by 50 mcg/hr. IV infusion, as well as Ceftriaxone 1g. Antibiotics have been shown to have a mortality benefit in patients with cirrhosis and upper GI bleeding.

TRANSFUSION

For the majority of patients, a transfusion threshold of Hb >7 should be used. For those with active ACS or ongoing bleeding, a higher threshold (8 or 9) may be used. Using a transfusion goal of Hb > 7 has been associated with improved survival and lower rates of rebleeding in stable acute upper GI bleeders when compared to a goal of Hb >9. Over-resuscitation can be particularly dangerous in patients with variceal bleeds.

Patients with a very low hemoglobin but who remain hemodynamically stable have likely been bleeding for several days and have compensated for ongoing blood loss with increased volume retention. These patients still require emergent transfusion, but it should be provided slowly (no more than 1 unit per hour) to avoid volume overload. Patients with an element of CHF, CKD, or AKI may require furosemide following transfusion.

Patients requiring more than 4 units of blood should be evaluated and treated for dilutional coagulopathy. For every 4 units of blood, 1 unit of FFP is warranted. If possible, a thromboelastography (TEG) should be obtained after 4 units of blood and should guide additional management. Patients with thrombocytopenia and platelet counts of <50k should receive platelet transfusions (1-unit platelet apheresis). DDAVP may also be considered in the setting of uremia and thrombocytopenia. In patients without cirrhosis, an INR >2 should prompt treatment with PCC or 1-unit FFP. In patients with cirrhosis, IV Vitamin K 10mg and cryoprecipitate 10U/1kg may be useful in correcting coagulopathy. TEG may be particularly helpful in guiding therapy for patients with cirrhosis. Reversal of anticoagulation should be considered based on the severity of the bleed and the original indication for anticoagulation.

AIRWAY

Hemodynamically stable patients with upper GI bleed still face high risk of aspiration. Their airway and mental status should be monitored closely, and intubation for airway protection may be required.

Cont'd on p. 4

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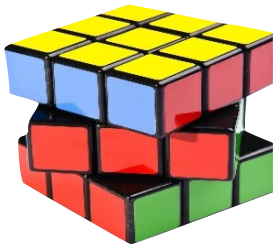


Red, Yellow, Blue: Base Station Review

CHATS Colors and EMS Pearls

–By Karen Baker, MD

Entering the ED you pass numerous EMS crews working on creative ways to squeeze their stretchers along the wall while also attempting to leave a viable pathway. Rather than using your PPE for cover to silently abandon ship, your first move is to discuss CHATS colors with the charge nurse.

YELLOW	*Emergency Department overwhelmed, requests but does not mandate diversion of Priority 2 and 3 patients.*
RED	*No telemetry beds available in the ICU or inpatient units. Free-standing EDs do not have this option.*
REROUTE	*Diversion request placed and removed only by EMS jurisdiction.*
BLUE	*County wide emergency status that overrides* **Yellow** *(blizzard, flooding, high EMS demand).*
MINI DISASTER	*Gas leak, bomb scare, utility outage. No patients can be safely received. Must be approved by MIEMSS.*
TRAUMA BYPASS	*Trauma attending requests trauma transports proceed to alternate facility that has not exceeded capabilities.*

After confidently requesting the **RAINBOW** the charge nurse agrees to discuss **Yellow** with the nursing coordinator. Meanwhile, that background ringing is not the recurrent malfunctioning fire alarm system, but the EMS box. No CHATS color status, aside from Mini Disaster, will stop a Priority 1 patient, STEMI alert or Stroke alert from arriving.

PRIORITY 1	*Critically ill or injured, requiring immediate attention, unstable with life-threatening injury or illness*
PRIORITY 2	*Less serious condition yet potentially life-threatening injury or illness, requiring emergency medical attention but not immediately life endangering*
PRIORITY 3	*Non-emergent condition, requiring medical attention but not on an emergency basis*
PRIORITY 4	*Does not require medical attention*

You almost breathed a sigh of relief upon hearing it was NOT a Priority 1 patient, until realizing the box call is a trauma destination decision and possible helicopter request. Pushing aside your feelings for this arch nemesis, you confirm the local facility is on the call and listen to the consult.

ALPHA	*Patient meets trauma criteria by objective vital sign abnormalities or GCS ≤13*
BRAVO	*Patient meeting trauma criteria based on physical exam injury pattern/findings*
CHARLIE	*Patient meets trauma criteria by mechanism of injury not qualifying for the higher level classifications*
DELTA	*The odds and ends of high risk groups (advanced age/pregnancy), EMS judgement, anticoagulants, burns*

How does this apply to the request you are receiving?

ALPHA and BRAVO	*Helicopter dispatches without MD approval. When this consult occurs they may really be asking if they need to divert locally given instability or lack of helicopter availability/bad weather.*
CHARLIE	*Physician consult required to confirm patient meets Charlie criteria before helicopter dispatch or trauma center transport.*
DELTA	*Godspeed, goodspeed - May not require transport to a trauma center, but if they do, and helicopter is faster, consider approving flight ***A DNR B is not a candidate for flight****

THE DELTA TRAUMA

- ***Burns***
- ***Pregnancy >20 weeks***
- ***Provider Judgement***
- ***Anticoagulation (isolated antiplatelet agent excluded)***
- ***Age >65 + SBP<110***
- ***Age >55 with low impact mechanism (ground level fall)***

EMS reports a 30mph MVC with 18 inches intrusion and categorize the patient as a Charlie trauma. You ask for more info, and hear the patient is without complaint, a GCS of 15, no anticoagulation, and the intrusion was actually into the trunk, not into the passenger space compartment. Graciously recommending the patient can be well managed at the local facility, as a delta by provider judgement, you SIGN your consult sheet, and get to work.

HEY!

...can my psych patient refuse testing?

DON'T RISK IT!

good advice for bad situations

Long story short, ***YES they can***. It's a common misconception that patients presenting with suicidal ideation or unusual or bizarre behaviors automatically lack capacity and lose the ability to make decisions for themselves. In many cases, when these patients refuse the "psych work-up", including blood draw, and these days COVID testing, they may be subject to the full court press from security, being forcefully restrained while blood, urine and nasal specimens are obtained. But some patients ***do*** have the right to refuse this testing – even if they're suicidal and even if it prolongs wait times to procure a psych bed. So how's a poor ED doc to know who's who? Decisions should be based on the concept of capacity and the patient's ability to understand the situation, the risks and the outcome of their decision. Capacity is fluid and can change with time and circumstance (i.e. a patient is successfully medicated for hallucinations and psychosis and regains capacity). A patient can also have capacity for some decisions and lack capacity for other decisions (e.g. suicidal patients may refuse blood draw and sign a voluntary admission, but would not be allowed to leave the ED). If a patient is awake, calm, alert, oriented, coherent and in touch with reality, but happens to be suicidal, they have the right to refuse testing. Your best bet? Try your hardest to convince them it's in their best interest to go along with the process. For patients who obviously lack capacity (e.g. actively psychotic, combative or incoherent) the need to "restrain and obtain" is more obvious and easier to justify. But remember!! It's imperative to document your reasoning if you find it necessary to physically restrain a patient and obtain specimens against their will. In the wrong patient, this could be considered criminal assault and in the absence of documentation, plaintiff attorneys will "fill the void" with a story that serves their agenda. Confused? Don't worry! Feel free to reach out to us *at any time* to discuss a case. We'll also be addressing this issue in more detail in an upcoming edition of the full **"Approach With Caution"** newsletter and video.

"CAPACITY IS FLUID AND CAN CHANGE WITH TIME AND CIRCUMSTANCE"

'Til then, *Rhamin & Priya*

LISTEN UP!

- By Rose Chasm, MD

pediatric otitis media

Acute otitis media (AOM) is the most common diagnosis for which pediatric patients are prescribed antibiotics. However, pediatric AOM is often inaccurately diagnosed and reflexively over-treated with antibiotics. An erythematous tympanic membrane DOES NOT equal AOM. Crying and fever can result in a red tympanic membrane. Fluid seen behind the TM is often serous (noninfectious) otitis media, rather than true AOM.

3 Criteria Necessary for Diagnosis

- *Acute onset of symptoms*
- *Bulging (or other signs of middle ear effusion)*
- *Middle ear inflammation (erythema or otalgia)*

Antibiotic stewardship has led various organizations such as the AAP, AAFP, and IDSA to introduce two different approaches to the treatment of AOM:

Always treat the following patients:

Immediate treatment with antibiotics

- *Children <6 months old (some sources recommend <2 years of age)*
- *Toxic appearing*
- *Severe signs/symptoms*
- *Bilateral ear disease*
- *Otorrhea*
- *Persistent pain*
- *Fever >39C*

Consider in a *very select patient group*:

Initial observation for 48-72 hours without antibiotics

- *Otherwise healthy children >2 years of age*
- *Non-severe illness*
- *Unilateral ear disease*
- *Access to follow up within 48-72 hours*
- *Parental comfort / Shared decision making*

Treatment Pearls

When **antibiotics** are warranted:

- First-line treatment = high dose amoxicillin
- 90 mg/kg/day divided into two doses (max 3g/day)
- Use amoxicillin-clavulanate if child:
  - *Received beta-lactam antibiotics in previous 90 days* ***or***
  - *Has purulent conjunctivitis* ***or***
  - *Has recurrent AOM*
    - *For this Augment ES, 600 mg/5mL formulation with a lower clavulanic concentration is preferred to lessen GI upset and diarrhea.*
- Total **treatment time**
  - *Children <2 years old = 10 days*
  - *Older children = 7-day course*
- For significant **penicillin allergy** consider azithromycin or clindamycin

BLACK WIDOW SPIDER BITES

- By Michael Simpson, PA and Justin Wang, PA

"You know what? You're a spider, and I'm afraid of spiders…
But you're also a friend, and I'm not afraid of friends."
-Stuffy the Dragon from Doc McStuffins

Along with peaceful falling leaves, delicious pumpkin beverages, and football, fall brings with it the threat of creepy, crawly insects. As spiders come out to mate and become more active in the cooler months, they may accidentally come into contact with potential human victims in various locations such as dimly lit sheds, garages, basements, wood piles, and gardens. While most native spiders and their infrequent bites are benign, some like the black widow and brown recluse can be very serious.

The bites of common household or outdoor spiders are generally fairly innocuous and present with maybe local pain and slight erythema at the wound site. These injuries can be treated symptomatically with ice packs and NSAIDs for pain relief and anti-inflammatory effects. Tetanus prophylaxis if needed. Now let's review one of the potentially scary ones…

In the picture above, note the ominous appearance of the female Lactrodectus mactans sporting a shiny black body with red hour-glass marking on her belly. Black widow spider bites may initially present with a local "pinprick sensation," but can quickly progress to radiating pain significantly out of proportion to exam, sometimes accompanied by systemic symptoms of varying severity. Symptoms peak within 2-3h and can last 3-7days. See **Table 1** below for symptoms and their treatment

Complications may include compartment syndrome, rhabdomyolysis, pre-term labor or miscarriage, priapism, ileus, myocarditis.
Anti-venom should be given for severe symptoms that are unrelieved by previously mentioned therapies, but beware of possibility of anaphylaxis, serum sickness or other reactions.

Work up:

- ***Labs*** *are only needed if signs of systemic illness or plan for admission and can include CBC, CK, lactate and UA*
- ***Poison control*** *for significant symptoms.*
- ***Observe*** *for 12-24 hours for all but minor symptoms*
- ***Admit*** *those at extremes of age, pregnant, and those with severe symptoms*
- *Otherwise* ***discharge*** *with analgesics and muscle relaxers for pain relief*

Pitfalls: Beware of working up a patient for a surgical abdomen while neglecting the possible diagnosis of spider bite. Similarly, the facial swelling and muscle spasm that is classic of this envenomation can mimic anaphylaxis, but should not be treated as such. Finally, calcium gluconate is NO LONGER recommended for treatment of black widow spider bites.

Table 1

SYMPTOM	TREAMTENT
Minor erythema and wound at envenomation site (sometimes with "target" appearance)	Cleansing, loose compression and immobilization of site (if possible), ice, TDAP
Severe pain in extremity or bite site, muscle spasms extending to trunk & abdomen (could mimic a surgical abdomen)	NSAIDs, +/- narcotics and muscle relaxers
Headaches, diaphoresis, tachycardia, tachypnea, N/V	Anti-emetics, fluids and pain control
Severe hypertension	Usually resolves with pain and spasm control. Consider IV antihypertensives in patients with co-morbidities who cannot tolerate elevated blood pressure
Seizures and/or respiratory arrest (rare)	Benzodiazepines and airway control

OLD DRUG - NEW TRICKS

Droperidol Use in Adults

-By Olakunle Gbadamosi, PharmD

After years of national shortage and black box warnings for QT prolongation, droperidol has made its way back to the US market. A first-generation antipsychotic, droperidol exerts its effects primarily as a dopamine receptor antagonist, and has some antagonistic activity at histamine, α2, and serotonin receptors. Since 2001 multiple studies have consistently shown it to be an effective and safe option.

Indicatlons

- Acute agitation
- Adjunctive therapy for **refractory** nausea/vomiting
- Adjunctive therapy for acute pain exacerbations in opioid tolerant patients
- Migraine headaches
- Inadequate response to other treatments and/or side effects

Requirements

- Obtain ECG to check for QTc prolongation prior to administration
- Telemonitoring advised for cumulative dose ≥ 2.5mg

Contraindications / Exclusions

- Documented QTc prolonging history or medications
- Predisposing factors such as CHF, significantly reduced EF, bradycardia, diuretic use, hypokalemia or hypomagnesemia, cardiac hypertrophy

Warnings / Precautions

- Black Box Warning: QTc prolongation even at low doses (generally dose dependent)
- Use of other CNS depressants (benzodiazepines and IV opiates)
- Pregnancy Category C
- Patients > 65 years of age
- History of seizures or alcohol abuse

Administration

- Nausea/vomiting: 0.625mg - 2.5mg IV/IM
  - *May administer an additional 1.25 mg IV/IM in 1 hour*
- Headache: 2.5mg- 5mg IV/IM
- Acute agitation: standard dose 5mg IM (up to 10mg per some sources)
- Pain: 2.5-5mg IV/IM
- Slow IV push over 5 minutes
- +/- diphenhydramine to minimize dystonic reactions

Adverse Effects

- Akathisia, tardive dyskinesia
- QTc prolongation (dose dependent/arrhythmias)
- Hypotension

Comparison to Other Medications

- Compared to Haldol, **droperidol has:**
  - *Quicker onset (5-10mins) and shorter duration of action (2-4hrs)*
  - *Significantly decreased combativeness (more sedating)*
  - *Less need for additional sedatives*
- Droperidol IM has same onset of action as midazolam IM but lasts twice as long

GI Bleed cont'd from p.1

The Unstable GI Bleeder

Access 2 large-bore IVs should be placed immediately. If peripheral access cannot be obtained, central access with a MAC, Cordis, or HD catheter is preferred over a standard Triple Lumen to allow rapid infusion of blood products. However, a Triple Lumen will work if it is the only option available. Transfusions can run through an IO while pending additional access.

Airway Patients with unstable upper GI bleeds may require emergent intubation for airway protection and/or facilitation of additional therapies (such as Blakemore or Minnesota tube placement). Anticipate needing significant suctioning to visualize the cords. An NG tube should be placed following intubation.

Transfusion Patients should be transfused only to the extent allowed to achieve permissive hypotension, defined by SBP 80-90 or MAP 65. A femoral arterial line is recommended to adequately assess BP response and avoid over-transfusing.

Activate massive transfusion protocol. PRBCs, FFP, and platelets should be given in a 1:1:1 ratio. Keep in mind that 1 unit of apheresed platelets is considered the equivalent to 6 units pRBC, the order will be 6u pRBC, 6u FFP, 1u apheresed platelets. Transfusions should be given through a warmer to avoid hypothermia. Each unit should be given over 15 minutes (or faster if the patient is able to tolerate it).

Electrolytes Patients with liver disease are at higher risk of hypocalcemia due to blood transfusions. Ionized calcium should be monitored and replaced as needed. In the absence of labs, the following empiric replacement protocol may be utilized:

- 10-20mL 10% Ca gluconate IV for every 500mL blood transfused
- 2-5mL 10% CaCl IV for every 500 mL blood transfused

Patients with severe renal insufficiency may be at higher risk of hyperkalemia due to transfusions. Potassium should be monitored frequently in these patients. Iatrogenic hyperkalemia may be minimized by washing pRBCs just prior to transfusion.

Pressors Vasopressors should be brought to the bedside early as they may be required while undergoing resuscitation to avoid dangerous hypotension. The principles of permissive hypotension still apply here; a MAP of 65 or SBP 80-90, or a normal mental status if the patient is awake, should be the goal. In addition to providing hemodynamic support, vasopressin (a somatostatin analogue) is a potent splanchnic vasoconstrictor and may reduce or stop variceal bleeding. The dose of vasopressin used here is higher than the standard sepsis dose: experts recommend a starting dose of 0.2-0.4units/min, doubled every 30 min until MAP >65 or bleeding stops.

Coagulopathy Reversal of anticoagulation (AC) should be considered in the context of the indication for AC. Selection of reversal agent and dosing should be determined by the anticoagulant in question. In the context of cirrhosis, there is limited evidence to guide reversal of coagulopathy. INR has been shown to be a poor indicator of coagulopathy, and empiric treatment with FFP has not been shown to be beneficial. If available, a TEG should be used to guide therapy. If TEG is unavailable, consider transfusing platelets if the platelet count is <50k, and cryoprecipitate if fibrinogen < 150-200mg/dL. PCC may be considered as well.

TXA has been recommended for refractory hemorrhage, and a 2014 Cochrane review previously reported a mortality benefit. However, the recent HALT-IT trial, representing the largest investigation into the use of TXA to treat GI bleeding, found no mortality benefit and a slight increase in rates of venous thromboembolism

Medications Same as medications for stable GI bleeder. Consider adding continuous infusion of PPI, e.g. protonix 8mg/hr.

Consultants GI, IR, and surgery should be consulted. However, a recent RCT demonstrated no mortality benefit associated with endoscopy performed within 6 hours, as opposed to 24. Of note, this trial excluded unstable patients whose endoscopy requirement might be different.

Cont'd on p. 5

Balloon Tamponade for Upper GI Bleed

GI Bleeding, cont'd from p.4

If after doing all the above, the patient remains unstable and with active hemorrhage, a balloon tamponade device should be placed to control the bleed. Variceal bleeds are caused by increased portal venous pressure leading to retrograde flow through the gastric vessels and esophageal veins. Both Blakemore and Minnesota devices use gastric balloons to tamponade vessels at the GE junction, preventing additional flow to the esophageal veins. In rare circumstances, inflation of esophageal balloon will be required to achieve sufficient tamponade.

Preparation

- *Intubate and paralyze patient prior to start of procedure. Use rocuronium to ensure patient remains paralyzed for the entire procedure.*
- *Have all equipment at bedside: Blakemore/Minnesota tube, Kelly clamps, OGT kit (include 50 cc syringe), tape/gauze, bucket of water, liter saline bag, Kerlex, IV pole, portable X-ray*
- *Immerse tube in water and inflate gastric and esophageal balloon to make sure both are intact (no bubbles in water), then fully deflate both balloons*
- *If using a Blakemore, tape an OGT to the Blakemore tube with the tip of OGT proximal to the gastric balloon (this will serve as your esophageal aspiration port)*
- *Clamp the gastric port with Kelly clamp (wrap with tape/gauze to avoid damage to port) or other device at all times when you are not inflating balloon to prevent it from deflating.*

Device Feature	Blakemore	Minnesota
Gastric balloon air amount	250-300 cc	450-500 cc
Esophageal balloon pressure	30-45 mmHg	30-45 mmHg
Gastric aspiration port	Yes	Yes
Esophageal aspiration port	No	Yes
Links to "How-To" videos for Blakemore & Minnesota insertion	https://youtu.be/NHelCd5Jtp4 https://youtu.be/6iiQdhibp3k	https://youtu.be/4FHIiA_doWU https://youtu.be/SVbn6Ozpvms

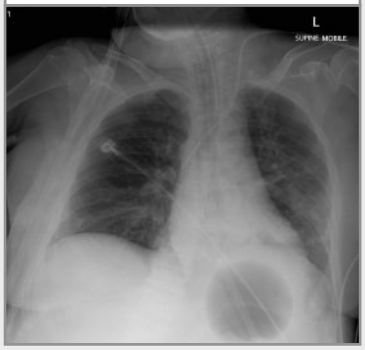
STEP ONE

Insert tube to 50cm and obtain XR to confirm location. You will have to position your hand as close to the esophagus as possible (in the patient's throat) to avoid coiling.

STEP TWO

Inflate the gastric balloon with 50cc of air and obtain 2nd XR.

STEP THREE



Inflate balloon with an additional 200-250cc of air if using a Blakemore, or 400-450 cc of air if using a Minnesota, and obtain 3rd XR.

STEP FOUR

Add traction (about 1kg= 1000 ml saline bag) and obtain last XR to confirm balloon is still in the stomach.

STEP FIVE

Maintain traction with either a pulley system (IV pole, Kerlix, saline bag), or by securing tube to ETT holder or rim of a helmet

STEP SIX

If you continue suctioning blood from esophageal aspiration port or OGT, you need to inflate esophageal balloon:

- *Attach 3-way stopcock to esophageal balloon port*
- *Attach manometer to end of 3-way stopcock and inflate to goal pressure of **30 mmHg**, can go up to 45 mmHg. Beyond this, there is a high risk of esophageal perforation.*

Orbital Compartment Syndrome (OCS)

- **RETROBULBAR HEMATOMA** accounts for up to 64% of OCS
- **Diagnosis** is made by clinical exam
  - ***Loss of vision***
  - *Proptosis*
  - *Ophthalmoplegia*
  - ***Afferent pupillary defect***
  - *Resistance to retropulsion*
  - ***Increased IOP (often >40mmHg)***
- **CT scan** (if performed for evaluation of associated traumatic injuries) can detect OCS:
  - *Tenting of posterior globe*
  - *Stretching of optic nerve*
  - *Proptosis*
- Retrobulbar hematoma with signs of orbital compartment syndrome can lead to **irreversible vision loss** within 60-100min, and treatment is with lateral canthotomy.
  - ***Vision should improve within 15 min** but may take up to 6 months to fully improve.*

LATERAL CANTHOTOMY

- REMEMBER the NUMBER 1
  - *1cc of 1% lidocaine with epinephrine*
  - *1 min of pressure with hemostat to lateral canthus*
  - *1cm lateral incision*
- **Final disposition** can be determined after definitive evaluation by ophthalmology
- MUST be evaluated for **definitive surgical treatment** even after successful lateral canthotomy

Check out this link to a pictorial guide and video of the lateral canthotomy procedure https://first10em.com/lateral-canthotomy/.

EmergenSEE
Ocular Emergency Pearls

By Victoria Hammond, MD

HOSPICE AND PALLIATIVE MEDICINE

At some time in our lives, we have all taken a trip to McDonald's or Burger King. Usually up on the wall there is a menu and from there you make your choices. You can choose sides, sauces, meats, buns, or the whole works. Have you noticed that when we have seriously ill patients, many emergency physicians tend to offer a similar menu of choices when it comes to artificial life support? Do you want everything? Would you like CPR? A breathing tube? It's very difficult for us to make these decisions even with our medical training and experience. Can you imagine what it is like for the layperson to be confronted with these types of choices? We have to do better. We must communicate with our patients and their families in a way where they can make difficult decisions based on their values and goals---NOT on the menu choices. There is no more critical time than now to have the kind of conversation that you never wanted to have…the one about setting goals and plans regarding medical care and treatments known as advance care planning. Any physician can have an advance care planning conversation with a patient during a primary care visit or even in the emergency department. Mr. Fred Rogers of Mr. Roger's Neighborhood, said it best: "Anything human is mentionable, and anything mentionable can be manageable." Being able to talk about death and bad outcomes makes this whole serious illness conversation manageable.

This article provides a simple approach to difficult conversations focusing on complex decisions surrounding serious illness and end of life preferences.

STEP 1 – IDENTIFY THE HEALTH CARE PROXY

Ask the patient or family member to ***identify the health care proxy*** – the person(s) who will be the patient's representative when he/she can no longer make decisions. Healthcare proxies can be spouses, adult children, siblings, or any other designated person. Ensure that everyone involved in the patient's care is participating in the discussion. Also, provide the option to revisit and or re-negotiate goals and decisions whenever circumstances change.

STEP 2 – ASK THE RIGHT QUESTIONS

To answer thorny questions about end of life we must know what we value. A clinician can provide guidance by asking the right questions. Instead of just reading the advance directive options, take a moment to ask the following questions: ***What is most important to you or your loved one? What gives you purpose and meaning in your life?*** Some patients value family gatherings while others prefer their independence or being in a garden surrounded by butterflies. The responses will vary from person to person as we all value different things.

STEP 3 – ASK THE DIFFICULT QUESTIONS

Knowing your patient's values, now it's time to ask the most difficult and dreaded question you never wanted to ask.

> ***"If you are so sick that you are unlikely to recover and would require artificial life support (i.e. CPR if your heart stops beating or breathing tube if you stop breathing) during the time you have left, would you prefer to continue on artificial life support, or would you choose to allow a natural death?"***

Everyone may have a different answer. Some may say, "I prefer Nature to take its course. I want to die naturally." Others may say, "Keep me alive at all costs, no matter what. I can't bear the thought of dying." What is most important is that the decision is based on the patient's values, not what their family, or even you as the provider, would prefer they choose. Emphasize to patient or poxy that there is no right or wrong answer.

STEP 4 – OFFER A RECOMMENDATION

Language is everything. Studies indicate that what listeners understand is often different from what clinicians intend. Certain phrases can lead families to feel abandoned and forced to choose between aggressive curative care and giving up. As emergency physicians, we should propose realistic goals.

> ***"Given that you said you most value being at home and hugging your children, I'd like to suggest home hospice."***
>
> ***"My recommendation is that we accept that he will not live much longer and allow him to die peacefully."***

INSTEAD OF SAYING…	TRY USING THIS LANGUAGE…
Do you want us to do everything possible?	*- Would you like us to initiate artificial life support or would you prefer to allow a natural death?* *- This disease is so deadly that no matter what we do, given her age and co-morbidities, it's not clear she'd survive.* *- What do I need to know in order to do a better job of taking care of you?*
- We'll refrain from extraordinary measures… **- I'm going to make sure he won't suffer.**	*- Your comfort and dignity are my top priority.* *- Can we agree not to escalate care, which is going to prolong the dying process?*
- It's time we talk about pulling back… **- I think we should stop aggressive therapy.** **- Will you agree to discontinue care?**	*- I want to help you live meaningfully in the time that you have left.* *- What can I do to help fulfill your wish to be at home with your family?* *- Let's concentrate on improving your quality of life.*

Decisions surrounding serious illness and planning for end of life is not a new phenomenon, but the presence of the COVID pandemic has made all of us a little more aware of our own mortality. We always hope for the best outcome with our patients and we must remember to tell them that, but we also must be practical, prepare for the worst, and be in alignment with our patients and their families.

JUST REMEMBER - GET RID OF THE MENU!

COMING UP in our next issue…

Management of Acute Vaginal Bleeding

by Michele Callahan, MD

…and much more!

Please let us know if you're interested in becoming a contributor or have a great idea for an article!