

POINTERS FOR THE ORAL BOARD EXAM IN EMERGENCY MEDICINE

T. Bottoni 10/2012

1. All women are pregnant until proven otherwise. Send a UHCG for 10-60yo.
2. If you think about sending a patient home, think again, "What am I missing?" Patients are seldomly sent home on the Orals; if they are sent home, be sure to arrange 24h follow up with the primary MD, via direct telephone contact.
3. Always run through DONT (dextrose, oxygen, Narcan, Thiamine) cocktail for any AMS patients. Remember multivits & Mg for any alcoholic or malnourished patients.
4. Always examine seizure patients for joint dislocations (i.e. posterior shoulder or hip dislocation).
5. Remember to use the high dose steroid protocol (30mg.kg bolus, then 5.4mg/kg/hr for 23h) for any trauma patient with an acute spinal cord lesion.
6. Consider ICP management for any head-injured patient with a blown pupil, posturing or signs of impending herniation---RSI, hyperventilation, mannitol, elevate HOB.
7. Always ask the EMT's to stay until you can talk with them. They often have precious history to offer. Also, use them to assist you and the RN's in the w/u.
8. Always ask family and friends to stay to offer history. Do not neglect them in the waiting room.
9. Always ask to have your patient completely undressed for examination.
10. Always explain to the patient (even if obtunded) and family what you are doing and why. This will score you points for interpersonal relations.
11. Always request old records/ECG's/XR's when needed.
12. Always order a calcium in AMS or cancer cases, to check for hypercalcemic disorders.
13. For unstable patients, resuscitate and stabilize first, then perform H&P.
14. Give proper attention to a complete initial set of vital signs. Request any missing vital sign; it is often abnormal and crucial to the management of the case.
15. Seek a rectal temp on infants, children, the elderly, any "sick" patient and any near drownings/cold water immersions.
16. Seek a quick accucheck on any "sick" or infected patient or child.
17. Seek a source of infection in any patient with DKA. (Check HCG for females.)
18. Examine patients carefully for medical alert tags/bracelets or other clues to the case.
19. Begin prompt, appropriate antibiotics for any identified infection.
20. If you give a medication before verifying patient allergies, the patient will invariably be allergic to that med.
21. All children with head injuries have hemophilia until proven otherwise.
22. Remember to give tetanus booster (Tdap) for any wounds, bites, burns.....Use DPT for kids, and offer Hypertet Ig too, for unimmunized patients.
23. Avoid sending patients unstable outside the ED for studies, unless accompanied by an MD/RN.
24. Demonstrate anticipation of problems: have airway equipment, drugs, pacer pads....on standby and ready to go if needed.

25. Be succinct with consultants: tell them what you have, what you've done and what they will need to do. Ask for recommendations, if necessary, and procure an appropriate inpatient bed.
26. Order a T&C immediately on any trauma or hypotensive patient.
27. On a triple case: leave an RN with each patient, and with instructions for serial monitoring and VS/lab updates, while you move on to subsequent patients.
28. If the patient is anxious, speak calmly.
29. Be tolerant of difficult personalities – patient, family or consultant. Use a chaplain, family member or other liaison to defuse tension.
30. Explain/warn the patient about any painful or embarrassing procedures or questions.
31. Ascertain a response to any patient intervention, then move on.
32. If you do not know the name or dose of a med, offer to look it up or confirm with pharmacist/PDR. (Resource Utilization)
33. Be sure to use a warmer for blood products, massive fluid infusions or DPL lavage fluid. Also, use blankets or Bair Hugger to keep exposed patients warm.
34. Note any breath odor for clues to DKA/ingestions.
35. Check orthostatic VS on any patient with abdominal pain, unless pale or tachycardic.
36. Check bilateral BP's on any HTN patient, as well as those with CP, victims of falls or MVC's or other deceleration injury, to uncover dissection or transection of aorta.
37. If a patient has neck pain with a good trauma mechanism, or AMS, perform a neck CT, despite negative plain films.
38. For all "sick" or elderly patients, immediately place on a cardiac monitor and O2, and start an IV. Seek an up-front rhythm strip for clues before a 12 lead ECG.
39. Place all supine pregnant patients (>2nd trimester) in left lateral decubitus position to avoid IVC compression syndrome.
40. Don't forget to logroll all trauma patients at end of secondary survey, to check back. Perform G/U and rectal exams here.
41. Order a PT/PTT/INR on obvious trauma, potentially preop cases, hemophiliacs, poisonings, known liver disease, coumadin patients or alcoholics.
42. Seek head CT on any elderly, alcoholic or patient on coumadin, following any head injury.
43. Fractured pelvis present? Perform RUG, then IVP, then Cystogram.
44. Call Poison Control for all poisonings!
45. Pregnant trauma patient? Check Kleihauer-Betke test. Give Rhogam within 72h. Use O neg blood if immediate transfusion is needed.
46. Nipride is the drug of choice in malignant HTN; avoid Esmolol or Labetalol in cases of suspected cocaine or sympathomimetic exposures.
47. Be sure to give activated charcoal to most all poisoned patients, unless contraindicated.
48. Perform an LP on any febrile patient with a headache, unless contraindicated. If you must seek a head CT first (HIV, cancer, transplant patient...), start empiric antibiotics before sending to CT.
49. Think of rhabdomyolysis in any burn or crush patient, or any patient lying around for some time (alcoholic, OD, CVA, postictal)
50. Any patient with a tense arm or leg following recent trauma has a compartment syndrome until proven otherwise. Check compartment pressures!

51. DDX of tetanus: meningitis, encephalitis, dystonia, head and neck infection (i.e. Ludwig's angina), narcotic withdrawal, strychnine poisoning, tetany (from hypocalcemia- s/p para/thyroidectomy), rabies.
52. Remember to check a rectal and G/U or pelvic exam on all hypotensive or bleeding patients, or anyone who might receive thrombolytic therapy.
53. If you see an IWMI, perform a right-sided ECG to check for posterior extension. If the patient is hypotensive, use IVF boluses first, then dobutamine.
54. For most poisonings with associated hypotension (i.e. TCA) treat with IVF first, then an alpha agonist pressor like Levophed. Avoid dopamine and dobutamine as pressors in Tox cases.
55. Call consultants promptly at the end of primary survey in emergent cases (i.e. trauma or general surgeon, OB, intensivists).
56. Abdominal pain in the elderly, +/- Afib, out of proportion to exam--> mesenteric ischemia.
57. Aspirin poisoning: unionized form can cross cell membranes. Alkalinization will ion trap in urine. Must supplement with K+ to sustain urinary alkalinization.
58. Be sure to recognize promptly and address any abnormal vital signs and lab results; failure to do so may result in critical oversights in the management of the case.
59. Use evaporative cooling for hyperthermic disorders.
60. Ask about facial trauma while assessing the airway.
61. For AMS, run through DON'T cocktail and check ASA, APAP, EtOH and C-spine, CXR, AAS routinely, to assess for trauma or ingested toxins.
62. Whenever placing a patient on a monitor, request an immediate strip.
63. Leave all trauma and AMS patients in C-spine precautions. Ask the admitting consultant to finish the c-spine evaluation later.
64. For any occult, atypical or unexpected infection, always investigate the possibility of diabetes. Check an accucheck.
65. Anyone with DKA needs a full infection/sepsis and AMI w/u.
66. Feel the skin of any AMS patient. Is it hot or cold? Important clue!
67. Give steroids (100-200mg Hydrocortisone IV) to any patient with any endocrinopathy (over- or under-active).
68. Factor VIII replacement: 1 unit/kg raises F8 level by 2%. For head injury or preop, need full replacement at 50U/kg.
69. Any evidence of burn around the airway compels a rapid intubation.
70. Be sure to place an NGT in all burn patients to protect against an ileus.
71. Give Hypertet 250-500U along with, but at separate site from, Tdap, for tetanus prone wounds.
72. If you perform a needle cricothyrotomy, be sure to call ENT stat for subsequent airway management.
73. If there is any possibility of losing the airway----epiglottitis, CHF, burns, mass--- place rescue surgical airway equipment at bedside, and call ENT stat.
74. Examine the anterior fontanelle of all infants. Is it bulging or sunken?
75. Examine the retinae of all infants for shaken baby syndrome.
76. ABEM likes to present R mainstem intubations; be sure to pull back the tube before replacing it.

77. Chest pain of uncertain etiology in a young person---check urine tox screen for cocaine.
78. Chest pain + cocaine = admission! Avoid use of beta-blockers here!
79. Preoxygenate well before any intubation.
80. Bizarre behavior? Check for hypoglycemia/hypoxia.
81. Check an amylase/lipase with complaints of CP, abdominal pain, back pain or overtly “sick” patients.
82. If a device doesn’t work, check it or replace it promptly.
83. Look under all bandages, and the diaper. You will likely find something significant hidden there. Peel off the diaper in all infant exams! (It might be hiding a torsion or hair tourniquet!)
84. Cyanosis that doesn’t respond to oxygenation is either a large anatomic shunt or more likely, methemoglobinemia. Check a metHgb level when indicated.
85. Call burn center for any burn patients, after resuscitation and stabilization.
86. Request use of Broselow tapes for guidance in any pediatric resuscitation. If a pediatric intensivist is available, ask him to come to the ED.

Formula for Fluid Therapy in Burns (Parkland Formula Shortcut)

Hourly rate for first 8 hours = Body WT (kg) x %TBSA burned / 4 (maintenance not included)

Foley/NGT Sizes for Age

- <5yo – 5Fr
- 8 - 8Fr
- 10 - 10Fr
- 12 - 12Fr
- 14 - 14Fr
- 16 - 16Fr
- >18 - 18Fr

Pediatric ETT Size = 4 + age/4 (use uncuffed upto size 6.0)

Estimated Pediatric Weights for Age (kg)

- Newborn - 3
- 1yo 10
- 2yo 15
- 5yo 20
- 8yo 25
- 10yo 30
- 12yo 35