

The AAEM Critical Care Section: The Greatest Resource You've Never Heard Of

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Emergency medicine *IS* critical care. There isn't a magical central line fairy or intubation genie for us. Patients arrive derailing and we *often* get them at least back

on the tracks even while having very little idea what sent them off the tracks to begin with. It is a unique skillset.

But the ICU is different because so much of it is the long-term approach, the 4th-line agent, etc. Here is where AAEM-CCMS is so important: it's a group of emergency physicians (EPs) with an interest in critical care and some EPs who loved rounding so much they signed up for 1-2 more years of it in the ICU. But this group is about where the rubber meets the road, the needs of the EP in the pit with the critically ill patient. Whether a resource is prepared by an EP with a special interest in critical care or an EP intensivist, the major objective for the AAEM Critical Care Medicine Section is that it's written *by* an EP, *for* an EP.

Take the article in the last issue of *Common Sense*, for example, on whether andexanet alfa should really be adopted as strongly and quickly as some say. Should you really give it to your bleeding patients on apixaban? It's a medication for a critical problem seen in the ED more often than we wish and it's from AAEM-CCMS.

Read the andexanet alfa article: <https://www.aaem.org/get-involved/sections/ccms/resources/common-sense>

Then, there are the Critical Care Hacks. We have all figured out some little work-around that makes it easier to take care of critically ill patients. The Critical Care Hacks videos demonstrate some MacGyvering our colleagues have shared to improve your and your patient's day. Each hack comes with a tidbit education piece relevant to the hack, so you can quickly catch up on classifications of hypothermia as you rewarm your icicle of a patient.

Have a knack for the hack? <https://www.aaem.org/get-involved/sections/ccms/resources/hacks>

Did you catch the last AAEM Critical Care podcast where Dr. Farcy, AAEM Past President, speaks with Tiffany Osborne, Professor of Surgery and Emergency Medicine Acute and Critical Care Surgery at the Washington University School of Medicine in St. Louis, about the Surviving Sepsis Campaign (SSC) Hour-1 Bundle? What is the goal BP for a patient with an acute subarachnoid hemorrhage? Did the patient decompensate after intubation? Are you struggling with the 1-hour sepsis bundle? Did you know you can use an ultrasound to assess fluid status? These are some of the topics covered in the long standing AAEM Critical Care podcast.

Listen here: <https://www.aaem.org/resources/publications/podcasts/critical-care-in-emergency-medicine>

Posting for the first time this year is the new Mentorship Program for residents/students and attendings. Whether your interests are research, clinical applications, or fellowship or whether you are a junior faculty member or a seasoned pro, there's a good match for a mentee or mentor for you in AAEM. We recognize that we all need mentorship at different stages in our career. AAEM-CCMS wants to support both mentees and mentors to foster these dialogues.

Learn more: <https://www.aaem.org/get-involved/sections/ccms/resources/mentorship-program>

Finally, whether you are interested in sharing your critical care knowledge on a public stage or if you are looking for a critical care speaker for your institution's educational programming, the new CCMS Speakers Bureau is a place to check for the latest additions. All members of CCMS are invited to participate. We ask for a short sample of your speaking abilities so that anyone looking for a speaker can see how great you are.

Along those lines, we have opened our section meeting to new speakers to give Breve Talks. We want to give our novice speakers a platform to grow. Plus these talks can be used for submission to the Speakers Bureau.

Learn more: <https://www.aaem.org/get-involved/sections/ccms/resources/speakers-bureau>

Involvement in the Critical Care Medicine Section does not require a critical care fellowship; in fact most members are not fellowship trained. What sets us apart from all of the other critical care sections is that our mission is to support ALL emergency physicians who are interested in critical care, because we understand that the emergency department *IS* critical care. ●

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Critical Care Hacks

Cheyenne Snavelly, MD and Ashika Jain, MD FAAEM



Follow the QR code for a Critical Care Hacks solution to make rewarming a little easier

Passively rewarm

- Remove cold/wet clothing
- Give warm blankets
- Rewarm at 1.5 degrees Celsius/hour

Mild
(32-35C)
Shivering

Moderate
(28-32C)
AMS
No shivering

Actively rewarm externally, minimally invasive methods

- Warm IVF
- Bare hugger
- Be cautious with movement, myocardium prone to arrhythmias, *if central access needed, only femoral lines

Accidental Hypothermia

Invasive measures + Modified ACLS

- Airway: standard ACLS (warm air if possible), try to avoid depolarizing paralytics
- Breathing: no changes
- Circulation: consider ultrasound assistance
 - Vtach/Vfib shock x 1, at most x 3 then no shocks until > 30 degrees Celsius
 - European guidelines: Epi only if T > 30 with double the interval i.e. 6-10 min between doses (US no clear guideline)
- Active rewarming (IV fluids, bladder irrigation), bilateral chest tubes (high anterior/low posterior), peritoneal lavage, ECMO
- Time of death when warm and dead, i.e. >30 degrees (vague guideline)

*Likely futile efforts if K >12, T <14C

*Consider broad etiology, hypoglycemia, sepsis, drugs/EtOH, other toxic/metabolic

Pulseless

Severe
<28C
Unconscious

Invasive measures

- IVF
- Bladder lavage
- Chest tubes, right sided only to avoid myocardium stimulation
- Peritoneal lavage
- ECMO

