Peer Review
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Call to order at 815am.

After reviewing several recent cases and receiving generally positive feedback, we have decided to issue another memo discussing topics of recent review in our EMS system.

New pain treatment protocols are available for prehospital use. These allow EMS personnel to dose morphine more aggressively. I recommend that patients under 65 be started with 0.1 mg/kg dose for moderate or severe pain. There is good research to show that no patients will stop breathing from this and that many will need more morphine to get good pain relief. In patients over 65, we recommend that starting dose be 0.5 mg/kg, or half of the 0.1 mg/kg dose. Morphine should be given slowly to minimize nausea, euphoria, or flushing. Repeated doses

Field RSI and airway management
Another reminder to not make things worse. There is good reason to suspect that a difficult/failed RSI attempt is worse than no attempt because of the increased ICP, possible periods of hypoxia, delays in transfer, and other airway injuries. Each attempt at laryngoscopy that is unsuccessful should be followed by a significant change that is expected to make a difference, not just another try. A second intubator can try, but overall attempts at laryngoscopy should be minimized. If 2 or a max of 3 tried at laryngoscopy are unsuccessful, then another modality should be used. LMA, combitube, or lighted stylette are all options. There will be airways each of us cannot intubate. It is our responsibility as airway managers to adequately respond when we are unsuccessful in laryngoscopy.

Witnessed cardiac arrest.
Just a reminder that the first treatment for vtach or vfib arrest which is witnessed should be defibrillation. CPR and epinephrine is not the ACLS treatment for witnessed conversion to an unstable tachycardia, but electricity is. It is not necessary to start CPR or intubate patients who have cardiac arrest to a shockable rhythm. If things don't convert with a shock and initial CPR, then it would be appropriate to go back and stabilize the ABC.

Neuro exam and neuro deficits
LA prehospital stroke scale is part of the assessment for patients with possible focal neuro deficits. This is a very easy and effective way to check patients for a significant

stroke. Also, remember to check glucose (this is part of LAPSS) since this is consistently the largest fraction of stroke mimics that turn out not to be strokes. This scale is attached.

Field IVs for Nausea/vomiting/diarrhea patients are being requested by nursing staff. This is frequently unnecessary and is to be done at the discretion of the medics. If you are told to start one and the patient does not need it, it is OK to say so to the patch person. The reasons that an IV would be needed for a patient with N/V/D would be if they are in shock/have abnormal vital signs/or have reasonable probability of electrolyte disturbances (this would be someone who has been having symptoms for more than 24 hours in most cases, and generally would have abnormal vitals or significant other medical illness).

We will revisit the issue of whether **prehospital blood draws** can be used. This was previously tabled because there were more pressing issues with respect to the lab/ER relationship. We will take this to the appropriate VVMC ED committee.

Selective C spine protocol. Troy Hoke will assist Dr. Lang in gathering data and proposing a selective c-spine immobilization protocol. There is at least one good study from Michigan which showed that medics can safely clear c spines with their protocol. We will gather and discuss this at the next prehospital committee meeting.

Mast trousers are rarely used and not supported by medical evidence. They are currently required by AZDHS. Dr. Lang will contact Dr. Bobrow to find out when they can go off of the list of required things. Follow up next meeting.

BLS/ALS transport will be determined by medics in conjunction with a patch phone. When both ALS and BLS medics are on the scene, if the crew desires to make the patient a BLS transport, patch phone medical direction should be obtained to permit this action.

With no further business, meeting was adjourned at 915AM.

Respectfully submitted,
Todd Lang, MD