MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DRUG/DEVICE/PROTOCOL COMMITTEE

June 1, 2011--09:30 A.M.

MEMBERS PRESENT

Richard Henderson, MD, Chairman
David Slattery, MD, LVFR (via phone)
Michele McKee, MD, UMC
Eric Dievendorf, EMT-P, AMR
Gina Schuster, EMT-P, Community Amb
Jarrod Johnson, DO, Vice Chair, MFR
Eric Anderson, MD, MedicWest
Derek Cox, EMT-P, LVFR
Chief Troy Tuke, CCFD
Syd Selitzky, Henderson Fire Dept (Alt)

MEMBERS ABSENT

Chief Scott Vivier, HFD
Nancy Cassell, EMS Professor, CSN
K. Alexander Malone, MD, NLVFD
Mary Levy, RN, UMC
Scott Scherr, MD, Sunrise Hospital

SNHD STAFF PRESENT

Rory Chetelat, EMS Manager
Trish Beckwith, EMS Field Representative
John Hammond, EMS Field Representative
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Steve Johnson, EMT-P, MWA
Gerry Julian, Mercy Air
Chris Baker, RN, TriState CareFlight
Gregg Caplan, Boundtree
E.P. Homansky, MD, American Medical Response
Sarah Morrison, Las Vegas Motor Speedway
Rick Resnick, Mesquite Fire & Rescue
Steve Patraw, BoundTree
Scott Lethi, Desert Springs Hospital

CALL TO ORDER – NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, June 1, 2011. Chairman Richard Henderson, M.D., called the meeting to order at 09:32 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Henderson noted that a quorum was present.

I. CONSENT AGENDA

Chairman Henderson stated the Consent Agenda consisted of matters to be considered by the Drug/Device/Protocol Committee that can be enacted by one motion. Any item may be discussed separately per Committee member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Minutes Drug/Device/Protocol Committee Meeting, May 4, 2011

Dr. Henderson asked for a motion to approve the minutes of the May 4, 2011 Drug/Device/Protocol Committee meeting. A motion to accept the minutes was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Final Review of the Treatment Protocols

Dr. Henderson started off the discussion by reviewing the pending revisions first and then the itemized list of changes based on recommendations from previous meetings.

1. Morphine routes to include Intramuscular (IM)/Intranasal (IN) – Dr. Slattery stated that IN Morphine is not absorbed very well but didn't see a reason not to do IM Morphine. Dr. Homansky felt that IM Morphine has an erratic absorption where some people get very high spiked levels and others get very low levels. Dr. McKee agreed and stated that she is not in favor of Morphine IN or IM for pediatric patients because she has seen too many children with depressed mental status and respiratory drive. She felt that if Morphine is going to be given to children, it would be better to give it IV and have it be a standard dose. Dr. Henderson felt that there was not enough interest to include IM/IN routes for Morphine and to leave it as discussed but no action.
2. Cardiac Dysrhythmia: Bradycardia: adopt language that is consistent with AHA which allows Atropine to be used in an unstable patient. – Dr. Henderson stated that Atropine is already listed and no change is required.
3. Respiratory Distress with Bronchospasm: #8 add language to consider the use of Epinephrine for asthma. – After a brief discussion it was agreed to not consider the use of Epinephrine for asthma.
4. The pediatric Cyanokit dose needs to be determined as well as the alert box. –Dr. Slattery informed the Committee that they had originally supported the pediatric Cyanokit for a compassionate use approach in pediatric cardiac arrest with smoke inhalation patients. He stated that he mistakenly suggested that this can be put under a compassionate use protocol through the Institutional Review Board (IRB) where in a compassionate use protocol can only be used for any drug or device that is still considered investigational and has not been through the FDA approval process. This medication is already FDA approved for adults so it would fall under "off label" use which the FDA does not regulate. The decision on using a drug "off label" is based on an assessment of the risks and benefits and available data on the subject. Dr. Slattery stated that his proposal would be that this gets approved for pediatric cardiac arrest smoke inhalation patients as an "off label" drug using the dose that has been set in Europe for children. Dr. McKee stated that the recommended dose for pediatric patients is 70 mg/kg. She also recommended broadening the scope of indications to have it encompass the same recommendations as the adult population and when documenting the use of the Cyanokit, include it as the hydroxocobalamin kit and not the older kit that induced methemoglobinemia so there isn't any ambiguity in the documentation of which kit they are utilizing. Dr. Homansky questioned the liability of "off label" use. Dr. Slattery stated that he has researched this and the direction from the FDA is very clear that they do not want to restrict or regulate a physician's decision to use medication. He felt the decision will be made as a physician on the Medical Advisory Board (MAB) for any medication that we feel is appropriate for a group of patients based on consensus and the best available evidence. Mr. Chetelat suggested moving forward with the approval and he will seek legal counsel and get back to this Committee if there are any changes that need to be made. Dr. Slattery agreed and wanted to make sure an alert box was added stating that this should not distract from usual cardiac arrest management. Dr. Henderson wanted to push back from adding the alert box because it was a training point and the direction of this Committee has been to get training out of the protocols. Mr. Chetelat suggested leaving the language there currently and letting the Education Committee work on what belongs in protocols. The Committee agreed.

Dr. McKee made a motion to broaden the pediatric indications to encompass the same recommendation as the adult population, change the reference to the "Cyanokit" as Hydroxocobalamin, and to include the Pediatric Hydroxocobalamin dose as 70 mg/kg IVPB over 15 minutes. The motion was seconded and passed unanimously.

5. Inclusion of the pilot Induced Hypothermia Protocol – Mr. Chetelat stated that this has actually already been approved and no action is required.

Cardiac Arrest (Adult CCC CPR)

Mr. Cox advised the Committee that there was a suggestion to put an alert box in this protocol to indicate the use of mechanical chest compression devices.

Mr. Chetelat stated that the suggested language that was sent to him by Dr. Slattery reads: "to minimize provider injury from doing CPR in the back of a moving ambulance and to provide consistent and uninterrupted chest compressions for cardiac arrest victims, mechanical chest compression devices should be used if available during patient transit".

Dr. Anderson questioned if a patient has already been placed in the back of a rig and an auto thumper arrives on scene, does that change the plan and hold up transport to apply it. Dr. Slattery stated the intent of this is if you have the equipment in your rescue or ambulance you use it, if not you don't. If you are ready to transport in an ambulance that doesn't have it and another rescue or ambulance does, they don't stop the transport. Dr. Henderson agreed stating that he interprets it as saying: "enable its use, not mandate it".

Mr. Chetelat stated that a recommendation was made to add an alert box stating that if patient has return of spontaneous circulation, transport to the closest designated facility per the Induced Hypothermia protocol and questioned if the Committee agreed.

Dr. Slattery stated that language was already part of the alert box and was struck so he spoke with Mr. Hammond to add very simple language to transport to the closest cooling hospital as a reminder. Dr. Anderson wanted to verify that there is an exception for the rural providers. Dr. Johnson verified that the 50 mile radius is included in all of the transport destination protocols.

Burns

Dr. Slattery requested that item #7 in the first alert box be changed to suspected smoke inhalation injury. Dr. McKee questioned the differentiation and felt that a chemical burn should also be considered as an inhalation injury. Dr. Slattery stated that was an excellent point and the Committee agreed to leave it as suspected inhalation injury.

Cardiac Dysrhythmia: Bradycardia

Dr. McKee expressed the fact that when students are taught epinephrine dosing, they don't give it in milligrams (mg) per kilogram (kg), they give milliliter (ml) per kg because it is easier for calculation purposes and then you just specify high dose or low dose. She added that it's easier for people to recall the dosing when using ml but didn't know if this Committee would want to change that because it would be the only place in the protocols where ml/kg dosing instead of mg/kg dosing would be used. Dr. McKee also voice concern on removing the endotrachial tube (ETT) as a route for pediatric patients. She was unaware of any recommendations from a national organization to remove high dose for an endotrachial tube (ETT) and felt that it is still an approved route to use.

Dr. Henderson questioned keeping the ETT route when there is the intraosseous (IO) route. Dr. McKee stated that the only caveat would be if you have a young infant or newborn and the medic is having a problem getting an IO into a pretty small femur or tibia, going down an endotrachial tube is another option if there is no other access.

Dr. Henderson stated that the issue with changing epinephrine to ml/kg is that there are no other medications where we carry different concentrations and questioned if we would want to change it across the protocols.

Mr. Chetelat felt that this could be sent to the Education Committee and allow them to work on it because that is filled with our educators that are doing this everyday and they may be able to weigh in on that better. Dr. McKee agreed but still felt that the endotrachial installation should not be removed. Dr. Henderson agreed.

Cardiac Dysrhythmia: Monomorphic Ventricular Tachycardia
Dr. McKee questioned whether this Committee would consider concurrent volume bolus 20cc per kilo of saline for the pediatric Amiodarone to help avoid the hypotension or if that would go to the Education Committee as well.

Chief Tuke expressed the fact that this is another training issue. Mr. Cox noted that it is not in the adult protocol and the medics are doing it with the adults because it does cause hypotension.

Dr. Slattery asked if the discussion was still on cc's per kg. Mr. Chetelat answered in the affirmative. Dr. Slattery stated that he supported this recommendation especially with how rare pediatric events are even if it is not consistent across the adult protocols. Mr. Chetelat recommended allowing this to go to the Education Committee to see if they want to make that change based on their interpretation and what they are doing in the field.

Dr. Henderson recapped that the Education Committee will make the decision about the dosing and felt that the Committee should also enable them to make a decision on the alert boxes.

Dr. Slattery agreed but wanted to clarify that this protocol will be approved today by this Committee and the MAB today. Mr. Chetelat answered in the affirmative and added that assuming there are no contradictions at the MAB, it will be sent to the Education Committee for review and if they want to recommend some changes we will revisit it at that time.

Dr. Henderson suggested that the final vote include that this Committee delegated the Education Committee to make the decision regarding dosing and alert boxes without it coming back to the MAB. Dr. McKee questioned whether that means the ETT installation will not be removed. Dr. Henderson answered in the affirmative.

B. Final Review of the Operation Protocols

Legal 2000
Dr. Slattery questioned if the intent of adding the new language states that if the patient was cleared at one hospital, they go to Southern Nevada Adult Mental Health Services (SNAMHS) and if something comes up which rarely happens, that that patient should be brought back to the original hospital that cleared them. Dr. Henderson answered in the affirmative. Dr. Slattery felt that the language should be stronger and recommended to change the "may" to "shall". Dr. Henderson agreed stating that the word "may" looks like an option.

Dr. Slattery made a motion to change the language to read "Upon EMS activation to Southern Nevada Adult Mental Health Services, stable patients shall be transported to the hospital that recently medically cleared the patient, even if that facility is not the closest or has the lowest hold census". The motion was seconded and passed unanimously.

C. Final Review of the Procedure Protocols

Dr. Henderson asked the Committee if there was any discussion or changes needed regarding the Procedure protocols. No discussion or action was taken.

D. Final Review of the Formulary

Dr. Slattery stated that the only item that is not listed in the formulary is Hydroxocobalamin which needs to be added.

A motion was made to approve the Summary of Changes along with the recommended changes. The motion was seconded and passed unanimously.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

None

V. ADJOURNMENT

As there was no further business, Dr. Henderson called for a motion to adjourn. The motion was made, seconded and passed unanimously to adjourn at 10:13 a.m.