PRC Meeting

Wednesday, July 13, 2022
9:30 AM to 12:00 PM
****The Committee does not anticipate a need for a closed session during this meeting****
****VIRTUAL / IN-PERSON HYBRID****

Meeting called by:	Dr. Timothy Chizmar
Type of meeting:	Protocol Review Committee

PRC Agenda Items

Call to order		Dr. Chizmar
Approval of minutes	May 2022 minutes	
Announcements		Dr. Chizmar
Old Business	IV Nitro Pilot Push Dose TXA for Wilderness EMS	Dr. Sward Dr. Millin
New Business	POCUS Carotid Blood Flow	Dr. Stone
Journal Club	National Guidelines for the Field Triage of Injured Patients (article)	Dr. Chizmar
Discussion(s)	Hangings/TOR Trauma Decision Tree and the New National Guidelines Patient Refusals – EMR Pediatric Respiratory Rates for Rescue Breathing and HPCPR	Dr. Stone Dr. Chizmar Dr. Chizmar Dr. Anders
Adjournment		Dr. Chizmar
Next Meeting	September 14, 2022 9:30am-12:00pm	

Protocol Review Committee Meeting Minutes

July 13, 2022

Attendance:

Committee Members in Attendance (In-person/Virtual): Kathleen Grote, Dr. Jennifer Anders, Dr. Steven White, Dave Chisholm, Gary Rains, Dr. James Gannon, Dr. Roger Stone, Dr. Matthew Levy, Dr. Janelle Martin, Dr. Jeffrey Fillmore, Dr. Jennifer Guyther, Dr. Timothy Chizmar (Chair), Meg Stein (Protocol Administrator)

Guests: Pete Fiackos, Ben Kaufman, Dr. Doug Floccare, Dr. Michael Millin, Nick Wagner, Mike Cole, Dr. Jonathan Wendell, Dr. Kashyap Kaul, Erich Goetz, Dr. Ruben Troncoso, Cyndy Wright-Johnson, Dave Sabat, Terrell Buckson, Jon Krohmer, Dr. Eric Garfinkel, Dr. Asa Margolis
Excused: Mary Alice Vanhoy, Rachel Itzoe, Mark Buchholtz, Dr. Thomas Chiccone

Alternates: Tim Burns

Absent: Mary Beachley, Tyler Stroh, Melissa Fox, Marianne Warehime, Dr. Kevin Pearl

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Meeting called to order at 9:35 by Dr. Chizmar.

Minutes: A motion was made by Kathleen Grote and seconded by Dr. Levy to approve the May 2022 minutes as written. The motion passed without objection.

Announcements: Dr. Chizmar welcomed new Career ALS Representative, Dave Chisolm, and Alternate Career ALS Representative, Tim Burns, to the committee.

JAC Representative, Chief Richard Schenning, has retired and his position on the committee is currently vacant. JAC is responsible for appointing a person to fill the position. The Board of Physicians position also remains vacant.

Old Business:

IV Nitro Pilot – Presented by Erich Goetz (Dr. Sward was unable to attend): The original proposal presented in the May PRC meeting has been modified to reflect suggested changes. The proposal is now for a Pilot rather than an Optional Supplemental Protocol. Indications are for adult patients with severe pulmonary edema who are already on CPAP with SBP > 160 mmHg or MAP > 90 mmHg. Dosing would be 400 mcg slow IV that may be repeated once in 5 minutes, titrated to SBP reduction of 20% or SBP of 140 mmHg.

Dr. Chizmar thanked Dr. Sward and Paramedic Goetz and opened the floor for discussion.

The prevalence for need of IV Nitro in the field and evidence from other states was discussed. The only adverse effects reported in other studies were transient hypotension that resolved.

Adjustments to the dosing parameters for consistency with the sublingual dosing and to accommodate use of infusion pumps was discussed. Dr. Chizmar suggested 40-80 mcg/min as the dosing for infusion pumps.

Starting the Pilot Protocol mid-cycle in Harford County with the ability for other jurisdictions to be added quickly was discussed. Dr. Stone and Dr. Chizmar agreed that a mid-cycle start and review in one year would facilitate expansion of the protocol to an OSP.

Extensive discussion of blood pressure parameters centered on consistency for both IV nitro and high dose SL nitro throughout the Pulmonary Edema Protocol and concern for what the threshold SPB limit should be. Currently within the protocol 150 and 180 mmHg are given as threshold limits for SL nitro and the IV nitro proposal suggests 160 mmHg as the threshold. Paramedic Burns, and Dr. Floccare were in favor of SBP of 150 mmHg as the threshold. Dr. Chizmar asked if there were any objections to SPB of 150 mmHg as the threshold and there were none. Adjustments to MAP will also need to be made for consistency.

Discussion of the titrating dosing to reduction of SPB to 140 mmHg or 20% reduction in SBP was discussed with concern raise as to whether SBP of 140 mmHg is too low. Dr. Garfinkel and Dr. Levy expressed concern over giving nitro at SPB $\leq$ 160 mmHg. Dr. Floccare reported he has seen great success with giving nitro with SPB as low as 160 mmHg. It was agreed that the proposal go through SPB titrated to 160 mmHg which can be adjusted later, if needed, based on the pilot study results.

Whether or not to require a medical consultation was discussed and as per previous discussions, it was agreed that for the initial 2 doses, no consult should be required.

Dr. Chizmar asked for a motion on moving forward with the proposal. Kathleen Grote made a motion, seconded by Dr. White, to move the proposal forward as a Pilot with review in one year. With no objections, the motion passed.

Push Dose TXA for Wilderness EMS – Presented by Dr. Millin: Dr. Millin advised he will have his proposal ready for formal presentation I at the September PRC meeting. He advised that he will be incorporation the suggestion of slowing the push to 5-10 minutes by diluting the TXA and administering it via a large syringe.

The floor was open for discussion and it was noted that the modifications to the original proposal are a good compromise. Dr. Gannon also raise the question of whether IM administration was an option. Dr. Millin stated he was willing to consider IM as well as push-dose at the pleasure of the committee.

Dr. Chizmar asked if there were any objections to the modified proposal discussed today so that we can speed the process at the next meeting. No objections were raised and the proposal will go to a formal vote at the September PRC meeting.

New Business:

POCUS Carotid Blood Flow – Presented by Chief Tim Burns and Dr. Stone: Chief Burns presented the proposal which suggests that EMSOPS be allowed to pick and choose which uses of POCUS (point of care ultrasound) to employ within their jurisdiction and further to endorse use of POCUS to assess for carotid blood flow when considering TOR (termination of resuscitation). In situations with persistent PEA, POCUS can directly observe carotid blood flow instead of using ETCO2 as a surrogate. Dr. Stone pointed out that using POCUS to assess for carotid blood flow can be a good tool to avoid futile transports.

Dr. Chizmar opened the floor for discussion.

In discussion, it was agreed that the modular approach to use of ultrasound is a good idea. All uses of POCUS to determine carotid blood flow for TOR would need to be reviewed. Dr. Wendell made the point that carotid blood flow is not the only measure of blood flow that could be used in TOR, cardiac motion can also be assessed using POCUS. Levels of training and the pros and cons of assessing cardiac motion versus carotid blood flow were discussed. Dr. Wendell was concerned that novice POCUS users may use too much pressure and collapse the carotid artery during assessment. He also suggested that the femoral artery can also be used to assess for blood flow.

Dr. Chizmar asked for concerns or questions regarding the proposal. Chief Burns suggested taking out the line in the proposal that states “During CPR, use color flow US to monitor for ROSC.

Dr. Chizmar reminded everyone that he needs updates for everyone using ultrasound and data on their use since this is a pilot protocol.

Dr. White made a motion, seconded by Kathleen Grote, to move the proposal forward. With no objections the motion passed.

Dr. Chizmar thanked Chief Burns for the proposal.

Journal Club:

Discussion of the National Guidelines for the Field Triage of Injured Patients (article) was postponed due to time constraints.

Discussions:

Hangings/TOR: Dr. Stone discussed the hybrid nature of hangings in the setting of cardiac arrest with both asphyxial (medical) aspects as well as trauma. An argument can be made for treating hangings as a medical arrest when considering TOR. However, in ROSC, trauma (e.g., neck fracture) must be considered in determining transport to a trauma center versus a CIC. It was noted that many trauma centers are CICs but most CICs are not trauma centers. After some discussion, it was generally agreed that for TOR hanging should be considered medical but for ROSC they should be treated as trauma. Dr. Stone and Dr. Levy plan to collaborate on a proposal for the September meeting.

Pediatric Respiratory Rates for Rescue Breathing and HPCPR: Dr. Anders discussed differences between the Maryland Protocols and AHA Guidelines regarding pediatric rescue breathing and respiratory rates for cardiac arrest with an advanced airway. AHA have gone back to 1 breath every 2-3 seconds. The current Protocols do not incorporate the AHA Guidelines change. PEMA is working on a proposal to bring the Protocols into alignment with the AHA Guidelines.

Dr. Anders also reported that PEMAC is looking at the Pediatric Cardiac Arrest and HPCPR algorithms with the intent of providing a “bundle of care” in a good order to present as a protocol revision.

PEMAC is intending the have written submissions for the September meeting.

Patient Refusals by EMRs: Dr. Chizmar posed the question of whether EMRs should or could be able to handle patient refusals. There is no mention of this in the current Protocols. He pointed out that refusals are high-risk situations. During discussion it was agreed that both EMR assessment of patient capacity to

refuse as well as EMR ability to provide advice regarding risk to the refusing patient are questionable. EMR ability to document refusals was also mentioned.

Dr. Chizmar plans to bring a proposal back regarding EMRs and patient refusals at a future meeting.

Trauma Decision Tree and the New National Guidelines: Dr. Chizmar pointed out several changes in the new National Guidelines that differ from the current Protocols. Topics for discussion and consideration include changing from the current four Trauma Categories to two (Red and Yellow), transport guideline that may shunt patients away from the lower level trauma centers, as well as changes in assessing GCS, vital signs, and mechanism of injury. Dr. Chizmar asked for initial reactions and comments. No comments favored changes to our four category system or changes in transport destinations but merit was seen in some of the other topics.

Dr. Chizmar advised the Trauma Decision Tree and the National Guidelines will be covered in more detail in the September PRC meeting and he will have a proposal to present. The PRC will need to make recommendations but this will also have to go through SEMSAC, Trauma Net and the EMS Board.

Good of the Order:

Dr. Stone asked for a time-line for feedback regarding the Trauma Decision Tree. Dr. Chizmar asked for feedback to be submitted by September 1.

Protocol submissions and other requests for the September agenda need to be turned in by September 1.

A motion was made by Dr. Margolis and seconded by Drs. Troncoso and Stone to adjourn. With no objections, the meeting adjourned at 12:24 PM.