SAPA JOURNAL

The Society of Army Physician Assistants

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FIRST ANNUAL SEAN P. GRIMES SCHOLARSHIP AWARDED

Left to Right: Kevin Wilkes, Don Grimes

Received by LTC Donald Black

As most of you know the Society of Army Physician Assistants (SAPA) met last week at their annual CME conference in Fayetteville, NC. The highlight of the week is always the annual banquet. The preceding picture was taken at the banquet where the first "Captain Sean P. Grimes Physician Assistant Educational Scholarship Award" was presented.

Last year SAPA established the Captain Sean P. Grimes Physician Assistant Educational Scholarship Award in honor of the first PA ever to be KIA. Captain Grimes did his Phase II training at BACH. This year the scholarship committee selected the first recipient. The award of $3000.00 was presented by Captain Grimes" brother, Don Grimes.

The recipient was Kevin A. Wilkes. He is an Army veteran (Infantry) who deployed to Kosovo and has been in the Army several years. He is currently in a PA program at Nova Southeastern University in Naples, Florida.

SAPA PRESIDENT PRESENTS ROBERT M. SCULLY AWARD

Left to Right: Sherry Morrey, Steve Ward

Received by Steve Ward

Each year it is the privilege and discretion of the President of our Society to select or not select a person of our society to receive the Robert M. Scully Award. This award is meant to honor the member of our society that has proven to be of great service to, and enhanced the image of our society. This year I selected Sherry Morrey, someone who has worked long hours, been a one person fact-finding committee, a one person action committee, and a one person spearhead into the red tape that entangles all positive forward thinking actions that need to be made in the Army Medical PA profession. Sherry has been a member of SAPA for uncounted years. During her membership, she served in many capacities to

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The SAPA Journal staff and SAPA Board of Directors encourages membership participation in this publication. Feel free to use this forum to present your views on any topic you desire. The publication of clinical articles on any subject is also solicited, however, to reduce our workload, we do request articles be presented typed, double-spaced format, and on CD, Microsoft Word format. The editor reserves the right of final acceptance of articles as well as the right to serialize articles which are too lengthy to be included in a single issue.

include being Secretary and Active Duty Director. She was instrumentally involved with the Commissioning Task force for PA transition from Warrant Officers to fully Commissioned Officers in 1990 to 1992. She was an IPAP Instructor and the Army Representative to the task force to consolidate the three military PA programs to the current IPAP 1992-94, Deputy Division Surgeon 1st ID, Korea 1996- 97, PA Branch Chief and Phase II Clinical Coordinator 2002-2006. It is without hesitation and with great respect that I selected Colonel Sherry Morrey to receive the Robert M. Scully Award 2006.

HYPOTHERMIA

A CASE REPORT IN AN ACTIVE DUTY PARATROOPER

Received from Robert Oyler, PA-C

Introduction

Hypothermia is an infrequent but potentially fatal, preventable, emergency condition which should be recognized early and managed aggressively to achieve the best possible outcome. The clinical definition of hypothermia is a core body temperature ≤ 95°F (35°C). U.S. data were obtained from the Compressed Mortality File (CMF) maintained by CDC's National Center for Health Statistics. That data revealed that during 1979-1998, 13,970 deaths were attributed to hypothermia. The death rate for males was three times higher than that for females in every age group except for persons <15 years, and the elderly have the highest rate of death due to hypothermia. This case report will present an illustrative case and a discussion of the pathophysiology and management of hypothermia.

Case Report

A 25-year-old Active Duty Army E4 parachute rigger was evacuated from a field-training site by ground ambulance to his health clinic, after he collapsed at the 8-mile mark of a 12-mile rucksack march. The ambient air temperature was approximately 28°F during the exercise. He had altered mental status and was physically incapacitated for more than 3 hours. His rectal core temperature was 91°F. The Physician Assistant (PA) who received the patient at the clinic started 2 IV's with warmed normal saline (95°F) and administered 4 liters over a period of 3 to 3.5 hours. He also had the patient wrapped in warm blankets. After 3.5 to 4 hours, the patient had a core temperature of 95°F. He returned to normal mental status and was able to ambulate without assistance. He was released on quarters for 24 hours, and directed to follow-up the next day. On follow-up, the patient stated that he was doing well on the ruckmarch until the 6-mile turnaround point when he became fatigued and slowed down his rate-of-march. He progressively worsened and at the 8-mile mark he collapsed. He was unable to respond verbally or physically to the first responders on the scene. When taken to the clinic, the patient related that he could hear people talking but could not reply nor follow their requests. His clinical condition improved with the warmed saline IV's and warm blankets; however, he stated that he still felt tired and "out-of-it" when released. He was diagnosed with mild hypothermia. The patient was given an additional 72 hours quarters, put on a 30-day P2 (Temporary) profile for cold weather exposure, and counseled about prevention of cold weather injuries by a PA in Preventive Medicine.

After one month, the patient was followed-up for re-evaluation of his profile. He states he ran 4-miles with his unit that morning, but felt very fatigued afterward, and intolerant to the cold weather he was in at the time (ambient temperature was 30°F at 0700 hours that day). Another 30-day P2 (T) profile for cold weather exposure was issued to the patient, and he was informed to follow up in one month after being re-counseled about prevention of cold weather injuries. His risk factors included taking Percocet, having had 4 wisdom teeth removed a week prior to injury, being hypoglycemic and potential hypothyroidism. The patient also related he had not trained-up for the ruckmarch because he runs 4-6 miles a day. He felt he was in good enough condition to do a ruckmarch without training up for that event.

Physical Examination and Laboratory Studies

The patient is a well-nourished and well-developed Hispanic male.

Significant labs are as follows:
CK—554 (12 Dec)
TSH—4.81 [range 0.27-4.2] (11 Dec)
WBC—17.2, (11 Dec), 5.4 (12 Dec)
Diff—80 segs, 11 lymphs (11 Dec)
Glucose—57 (11 Dec)

Pertinent Medical History

He is allergic to penicillin, and was taking Percocet for pain, as above. Patient was also positive for shingles from 27 Dec 02 through 07 Jan 03. Otherwise, his medical history is non-contributory.

Discussion

The initial response to a fall in core temperature is peripheral vasoconstriction, followed by an increase in muscle tone and metabolic rate. As the core temperature continues to fall, shivering, tachypnea, tachycardia and hypertension develop. These symptoms become maximal when the core temperature is about 95°F (35°C). Below 95°F, the depressant effect of hypothermia begins to offset the metabolic activation. As the core temperature falls from 95°F to 86°F, metabolic rate, shivering, respiratory rate, heart rate and cognitive function all decline. The individual may become quiet and withdrawn or confused and combative initially, but eventually becomes obtunded. Furthermore, since the metabolic depression of hypothermia stops the hypermetabolic response to cold, the individual loses a substantial defense against additional fall in core temperature and the rate of its fall may accelerate. Below 95°, heart rate, blood pressure and respiratory rate decline roughly in parallel. Metabolic rate, oxygen consumption and cardiac output are about 50% normal at 85°F (29°C) and about 20% normal at 68°F 20°C). At these lower temperatures, ventilation and perfusion do not quite keep up with metabolic requirements and a mixed respiratory and metabolic acidosis develops.

Exhaustion hypothermia results when individuals exposed to cold weather conditions are unable, because of fatigue or injury, to sustain a metabolic rate sufficient to balance the loss of heat to the environment. Factors that influence the rate of temperature during exposure to cold land environments are:

1) ambient temperature and wind
2) clothing
3) precipitation reduces the insulating value of clothing and adds an additional source of cooling
4) rate of physical activity, an important mechanism of maintaining core temperature, normally lasts only as long as activity is maintained
5) dry shelter moderates the cooling effect of wind and precipitation, and may also provide an opportunity to rest.

The lethality and difficulty of managing hypothermia depends on the degree of core temperature depression. Thus, hypothermia is classified into mild, moderate and severe, based on core temperature. Mild hypothermia is defined as core temperature between 90° and 95°F (32° to 35°C), and casualties usually retain the ability to rewarm spontaneously without developing cardiac arrhythmias. Between 82° to 90°F (28° to 32°C), the range of moderate hypothermia, atrial arrhythmias become common and metabolic rate is depressed significantly to slow the rate of spontaneous rewarming. With severe hypothermia, defined by core temperature <82°F, spontaneous rewarming is markedly depressed, and the risk of ventricular fibrillation becomes substantial.

Clinical Presentation

The clinical manifestations of mild to moderate hypothermia are frequently subtle and may not be recognized until core temperature is measured. A clinical pearl is to be aware of the "umbles," i.e., patient stumbles, mumbles, fumbles and grumbles. If oral temperature is not over 95°F (35°C), a rectal temperature should be taken with a low reading thermometer. The table to the right shows the symptoms of the various stages of hypothermia:

BODY TEMP	SYMPTOMS	OBSERVABLE BY OTHERS	FELT BY PATIENT
(Early Stage) 98.6°FÞ95.0°F	Intense and uncontrollable shivering; impaired ability to perform complex tasks	Poor coordination. Slowing of pace. Intense shivering.	Uncontrollable fits of shivering. Immobile, fumbling hands. Fatigue.
(Moderate Stage) 95.0°FÞ91.4°F	Persistent violent shivering. Sluggish thinking, difficulty speaking, amnesia begins to appear.	Stumbling, lurching gait. Thick speech, mumbles. Poor judgment.	Stumbling. Poor speech, mumbles. Feeling of deep numbness or cold.
(Severe Stages) 91.4°FÞ87.8°F	Shivering decreases; replaced by muscular rigidity and jerky, erratic movements; thinking not clear but posture maintained.	Irrational. Incoherent. Amnesia, memory lapses. Loss of contact with environment. Hallucinations.	Disoriented. Muscles stiffen. Exhausted, unable to move after a rest. Decrease in shivering.
87.8°FÞ85.2°F	Irrational. Loss of contact with environment. Drifts into stupor. Pulse and respiration slowed. Muscular rigidity continues.	Blueness of skin. Slowed respiratory and heart rate. Pupils dilated. Stupor. Weak and/or irregular pulse.	Blueness of skin. Slow, weak and/or irregular pulse. Drowsy.
85.2°FÞ78.8°F	Unconscious; does not respond to voice; most	Unconscious.	

First Aid and Field Management

Hypothermia is confirmed by core temperature measurement. However, clinical thermometers are often unavailable in the field, and first responders may have to rely on their judgment of the casualty's clinical state.

All suspected victims of hypothermia should be considered at risk of sudden death from ventricular fibrillation or hypotension, and steps should be taken to prevent those complications. Handling should be minimal and gentle. Multiple layers of insulation to prevent heat loss should be placed around the casualty at the same time wet clothing is removed (if needed). Protection from wind and wetness is important. The insulation under the patient should be noncompressible. If it is not, it will rapidly become ineffective under the person's weight and allow significant heat loss. Airway heat loss should be prevented by any means available. One simple example is to place a scarf or non-occlusive bandage over the patient's mouth. Since dehydration and hypovolemia are common in hypothermia, an IV should be started with warmed fluid (LR, NS, D5/0.5NS). If 1) hypoglycemia, 2) alcoholism or 3) opiate intoxication are suspected, glucose (10-25 grams), thiamine (100mg) and naloxone (1-2 mg), should be administered IV. An injury survey should be done insuring appropriate dressing, splinting and stabilization is provided before evacuation.

Cardiopulmonary Resuscitation

Patients with severe hypothermia often appear to be in cardiac arrest. They are unconscious and without perceptible life signs. In this type of patient CPR should be started without hesitation because there is no risk of harm in excess of benefit. However, in the moderate hypothermic patient, there is a real risk of converting a perfusing quiet bradycardia into a ventricular fibrillation by external massage. Ventricular fibrillation greatly complicates and reduces the likelihood of successful resuscitation from hypothermia. If possible, cardiac monitoring and Doppler flow probes should be used in the field to determine the need for CPR. (Be sure to warm metal electrodes before applying to avoid frostbite injury to the skin.) If monitoring shows a regular ventricular rhythm and arterial flow can be detected by Doppler, CPR should not be initiated, even if pulse and/or blood pressure are not perceptible. Ventricular fibrillation requires external massage. Wide complex ventricular rhythms without detectable flow should probably also be given external massage. If cardiac monitoring and/or Doppler are not available, the following suggestion should be considered for implementation. Remember to take more time for hypothermic patients. The slow pulse rate may be difficult to detect. If the patient meets the criteria for CPR, begin such unless:

1) Any signs of life (respiratory effort, spontaneous movement) are present. These signs must be continuously reassessed to assure they persist. Their disappearance may represent a failure of perfusion due to ventricular fibrillation.

2) There are pre-existing orders not to resuscitate or a valid living will.

3) There are other obvious lethal injuries.

4) The chest is incompressible.

5) Performing CPR would be dangerous to the resuscitators.

6) Core temperature is less than 42°F (6°C).

7) Serum potassium is greater than 10 meq/l. (This may not be obtainable in the field, but is a reliable indicator of the for futility of resuscitation.)

CPR should be continued until core temperature exceeds 90°F and no evidence of effective cardiac function is present (i.e., pulseless electrical activity, asystole or agonal rhythm). Resuscitation can be discontinued if all of the following are true:

1) Core temperature (measured at the right or left atrium) is between 42° and 79°F (6°-26°C), the patient has no vital signs, electrical asystole is present and the documented period of arrest is greater than 5 hours.

Or

2) Core temperature (measured at the right or left atrium) is between 79° and 90°F (26°-32°C), the patient has no vital signs, electrical asystole is present and the documented period of arrest is greater than 12 hours.

Sudden Death in Accidental Hypothermia

Sudden death is a common complication in the rescue of hypothermic victims. Many examples abound of individuals who are alive, alert and able to move, only to die shortly after being rescued. Three factors are believed to contribute to sudden death in hypothermic victims: ventricular irritability, hypovolemia and orthostasis, and sudden intraventricular cooling.

The increased risk of ventricular fibrillation appears to be due to changes in ventricular impulse conduction. The hypothermic ventricle responds to mechanical stimuli with local action potentials. Casualties of hypothermia are usually hypovolemic due to minimal food and/or fluid intake and to cold diuresis. Immersion victims have an immersion diuresis (due to the displacement of blood volume into the central circulation by the outside pressure on the abdomen and extremities, especially the legs) in addition to cold diuresis. Hypothermia also depresses orthostatic reflexes causing venous blood pooling to occur in any upright posture. Muscular exercise increases blood flow to the exercising muscles, further reducing effective blood volume. The ultimate consequence of the hypovolemia, orthostasis and redistribution of blood flow is hypotension. Lastly, exercise and warming of the skin in hypothermic patients increase blood flow to areas that have been underperfused during cold exposure. The stagnant blood in these areas is acidotic, hyperkalemic and cold. If large amounts of this cold peripheral blood enter the central circulation, the ventricles are exposed to metabolic and temperature conditions (referred to as "post-exposure cooling" or "after-drop") that further aggravate the risk of fibrillation. The risk of sudden death can be moderated during rescue by ensuring that each of the above risk factors are controlled. Casualties should be kept quiet and supine. Sudden movements during rescue should be avoided. The patient should not be allowed to exert him/herself during rescue. Hypovolemia should be treated early.

Hospital Management

The key to success is the restoration of normal core temperature without causing complications. Techniques that use the patient's own inherent metabolic heat generation (present to some extent in every hypovolemic casualty) are called "passive rewarming." Those using external sources are referred to as "active rewarming."

Passive rewarming techniques provide sufficient insulation to the body and airway to prevent continued heat loss. This is effective even with a core temperature as low as 80°F (27°C). Depending on the effectiveness of the insulation, core temperature increases from 0.25° to 1°F per hour, and is appropriate only as long as the temperature is rising. This may take 24 to 36 hours to restore to normothermia. This method uses very few intensive care resources, allows for gradual re-equilibration and avoids the complications associated with invasive techniques. The disadvantages are the length of time to attain normothermia and the need for continued monitoring to ensure that core temperature is rising.

Active rewarming techniques of several types are used. Active "surface" rewarming techniques apply heat to the periphery (warm baths to trunk and/or extremities, heating blankets, warm towels to groin and/or axilla). These are not technically demanding and are helpful for mild and moderate hypothermia. However, there are three caveats. First, they are not effective if cardiac arrest has occurred. Second, by increasing blood flow to the skin and extremities before central rewarming has taken place, the active rewarming may increase the delivery of cold peripheral blood and precipitate cardiac cooling and hypotension. Third, since hypothermic skin is vulnerable to burning, careful monitoring of the heat source temperature is required. One technique of active surface rewarming is the application of warm (104°F) water soaked towels to the scalp,. The scalp has a low blood volume, but a high blood flow with rapid entry into the circulation. Therefore, heat can be delivered to the core without increasing the delivery of large amounts of cold peripheral blood. Active "core" rewarming is required for hypothermic cardiac arrest and for most severely hypothermic victims. There are four types of core rewarming techniques:

1) Intraluminal lavage: the two most common are gastric and intraperitoneal lavage. These are ample and effective, and raise the core temperature 0.5°to 1.5°F per hour. The primary risks are the procedures used to gain access (gastric intubation, insertion of intraperitoneal catheters, etc.) and aggravation of edema due to fluid overload. Direct myocardial warming by mediastinal lavage has been reported to resolve ventricular fibrillation and allow resuscitation when less invasive techniques have failed.

2) Ventilation with heated air is an effective rewarming method. A variety of apparatus for field and hospital use have been developed. An excellent review of the apparatus and technique is found in the Journal of Wilderness Medicine (Lloyd, E.L., 1990).

3) Cardiopulmonary bypass and hemodialysis are effective for rapid rewarming. However, these are only available in specialized centers, and are usually only done in extraordinary circumstances when other methods have failed.

4) Radiant energy using experimental devices with electromagnetic radiation in the microwave range have been reported. Such devices have not yet become available for clinical use.

Hypoglycemia may be a cause or consequence of hypothermia. If hypoglycemia is present, dextrose (25 cc of D50/W) should be administered stat. 100 mg of Thiamine IV should always precede the dextrose. Until it is evident that the patient can maintain adequate core temperature, such monitoring is required. After rewarming, management of any underlying or associated conditions should be addressed. The main post-warming complications are: pneumonia, pancreatitis, rhabdomyolysis, myoglobinuria and renal failure. Temporary left ventricular dysfunction has also been reported. Late complications include prolonged, occasionally permanent, cold sensitivity and sometimes contractures of the hands and/or feet.

Return to Duty and Physical Profiling

After complete recovery from hypothermia and any complications, the soldier may return to his/her unit with a temporary P-2 profile, allowing use of additional cold weather protective clothing, as needed. Non-regulation clothing is permitted under the regulation outer uniform. Unit leaders should be instructed to provide additional supervision to the soldier during cold environment exposure. If a recovered soldier exhibits any tendency toward cold intolerance or inability to perform in the cold, he/she should be referred to a PEB. Since hypothermia is frequently associated with other injuries (e.g., frostbite, trench foot), those other injuries may determine the convalescence and disposition of the soldier.

Conclusion

Individuals with the signs or symptoms of hypothermia should seek or be given immediate medical attention. Signs include shivering, altered mental status, numbness, fatigue, and lethargy. If the victim does not have a pulse, is not breathing and is unconscious, CPR should be done in conjunction with warming efforts.

Prevention strategies include education of personnel subject to cold weather environments and health-care providers about heat preservation tactics. Risk reduction should be a part of all leaders planning during cold weather training and operations.

Recommended Reading

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SAPA SCHOLARSHIP GRANTS 2006

Received by Harold Slusher

The SAPA Board of Directors proudly announces that there will be five (5) $1,000.00 grants available to be awarded to five lucky scholars for this year. Scholarships are available to SAPA members, their spouse, and children of SAPA members who are fully dependent on the sponsor and are under the age of 24. The person must be enrolled or accepted to be enrolled in a college, university, or a school of equal educational standing which awards a degree or certificate qualifying for a profession. Children in elementary, middle and high school are not eligible.

The application packet should include (but is not limited to) the following:

A personal letter telling something about yourself, your educational goals, career aspirations, why you need the scholarship, and anything else that might be of interest to the scholarship committee. Included in the letter should be how the applicant qualifies to apply for the scholarship including who is their sponsor if a dependent.

A listing of awards, decorations, commendations, honors, hobbies, activities, volunteer activities and anything else that may be of interest to the scholarship committee.

Two letters of recommendation; one from an educator, one from outside the educational field. Family members are not eligible to write letters of recommendation.

Proof of registration to a school or a letter of acceptance.

Recent transcripts of grades or placement test scores if recent high school graduate.

Recent photo, passport style.

Anything else that may be of interest to the scholarship committee.

All completed packets will be forwarded to:

SAPA Scholarship Committee
PO Box 07490
Fort Myers, FL 33919

All packets will be reproduced and forwarded to each member of the scholarship committee. All packets become the property of SAPA. The decision of the committee is final and once the decisions are made the awardees will be notified immediately and the check will follow shortly. Those who do not win will also be notified. The decision process is quite exacting and time consuming so patience from the applicants is expected.

It is hoped that the scholarships will be available to be awarded by 1 September so all application packets must be received by 15 August 2006.

Get to work on your packet and good luck to all.

SOCIETY OF ARMY PHYSICIAN ASSISTANTS
P.O. BOX 07490
Fort Myers, FL 33919

First Class

ADDRESS CORRECTION REQUESTED

ATTENTION SAPA MEMBERS

Your desired AAPA constituent chapter may not be accurately reflected in AAPA's own records. Why, you ask, is that important? Because, all constituent chapters are only authorized a certain number of delegates at the annual House of Delegates Meeting. This meeting is the only forum at which your designated constituent chapter has national representation. The number of authorized delegates is directly correlative to how many "Fellow" members of a given chapter select that chapter as their constituent chapter. Your SAPA Board of Directors, led by Paul Lowe, the Membership Director, recently discovered multiple discrepancies in the AAPA constituent chapter entries. Several members were certain that they had selected SAPA as their constituent chapter, but were surprised to find out the AAPA's records reflected a different chapter. Other members were accurately and appropriately listed on line as having selected SAPA as their constituent chapter, but were not included on the list sent by the AAPA to Paul. The BOD is working hard to correct this situation. I encourage you all to verify or confirm that the AAPA has accurately reflected your chosen constituent chapter. This can be accomplished by logging on to the AAPA website http://www.aapa.org/ Click on Members Only, then Click on Use AAPA Member Directory (members only). Then follow the directions to enter your AAPA ID and password. Click on Edit your Personal Information. You should see your designated constituent chapter. If incorrect, follow the directions to edit. It is also important to renew your AAPA membership dues by 31 January each year, in order to be cosidered current for the purpose of establishing your desired constituent chapter. Let's all rally around this issue to insure SAPA always has their appropriate number of delegates. **(CB)**

MISSED OPPORTUNITY

I was very surprised and overcome with emotion when inducted into the SAPA Hall of Fame. I have no other excuse for failing to express how much I love SAPA and its many members who make it the best organization I've ever been affiliated with. I pledge my continued service. **(CB)**