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Manual of Emergency Medicine

Fourth Edition

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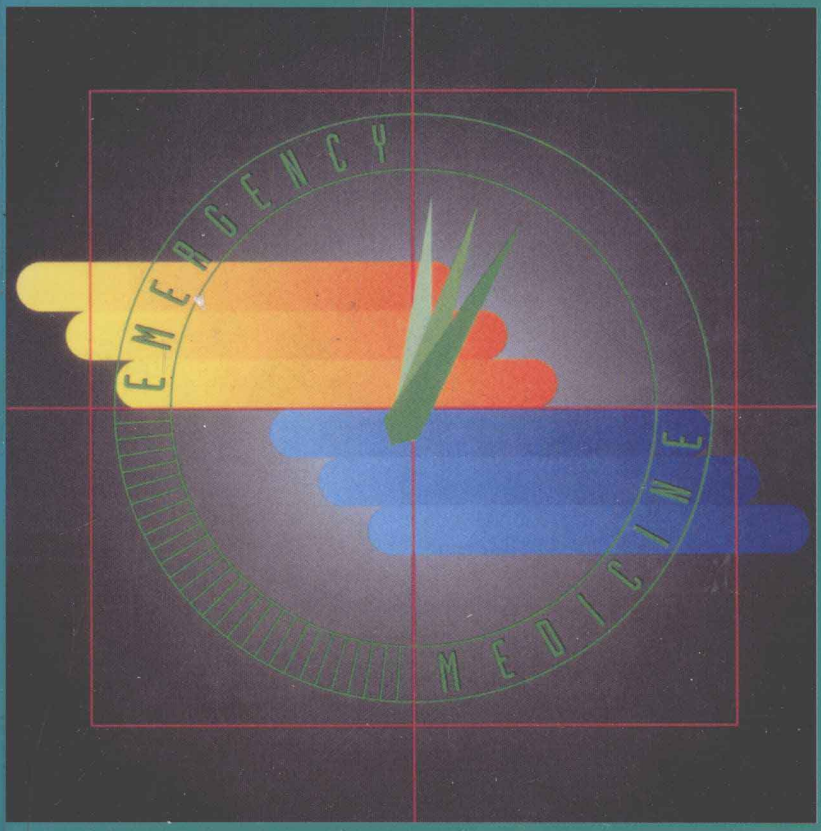
急症医学手册

Edited by
Jon L. Jenkins
G. Richard Braen



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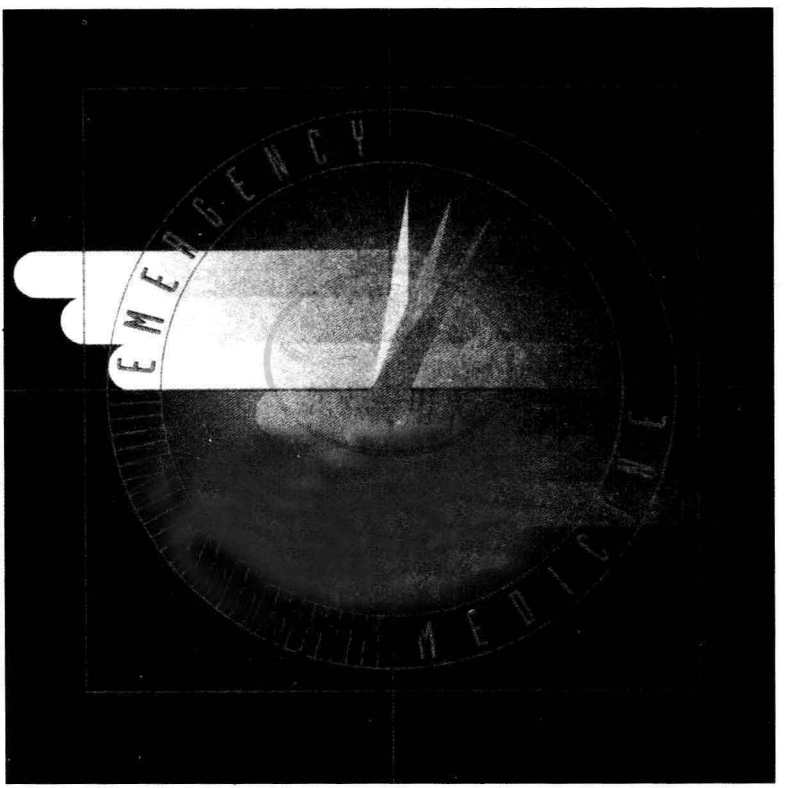

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Manual of Emergency Medicine

FOURTH EDITION

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To our wives, Cathy and Kate, and to Anna Maye.

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PREFACE

Since publishing the first edition of ***Manual of Emergency Medicine*** in 1986, we have consistently revised the text based on scientific and clinical advances in emergency medical care and changing patterns of practice. We thoroughly updated this current edition; approximately 30% of the material is completely new or significantly revised. New chapters have been added, including trauma and drug therapy in pregnancy, mechanical ventilation, HIV and AIDS, and pain management. We expanded the psychiatric section to include chapters on the initial evaluation of the psychiatric patient medical clearance, managing agitation and aggression in the emergency department, assessing suicide risk, and evaluating and managing drug- and alcohol-related problems.

We believe the Manual provides a practical guide for the initial evaluation and management of both common and potentially life- or limb-threatening conditions encountered in emergency medicine. We wrote the Manual in a style and format valuable to physicians at every level of training and experience.

This Manual, because of size limitations inherent to the series, cannot provide the comprehensive or definitive standard of care for all patients. Additionally, the authors acknowledge that there are varieties of acceptable and appropriate management strategies for many conditions in emergency medicine, that medical opinions among experienced and thoughtful emergency physicians often diverge, and that few absolutes exist in medicine; recommendations made in this edition, as well as in prior editions, must be interpreted in this context.

We are indebted to the many authors who contributed to this and past editions. Also, we are grateful for the numerous readers and reviewers who, over the years, have shared their comments and thoughts with us. To further facilitate this feedback, we invite you to e-mail comments to the following addresses:

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I. CARDIOPULMONARY ARREST

1. CARDIOPULMONARY RESUSCITATION

The techniques and strategies of cardiopulmonary resuscitation have evolved over the years into an organized framework for the evaluation and treatment of patients suffering respiratory or cardiac arrest. It is reasonable for the emergency physician to consider these recommendations, based on currently available data, to be the best initial approach to most patients presenting with cardiorespiratory arrest; one understands, however, that the recommendations evolve continuously, and often dramatically change, suggesting that our understanding of the pathophysiology of this illness is partial at best, and certainly not optimal.

In the emergency department, basic cardiopulmonary resuscitation (CPR) must proceed simultaneously with advanced resuscitation, the latter employing both medications and electrotherapy.

I. **Basic CPR** focuses on the "ABCs," ensuring first that the airway is patent and adequate; second, that breathing is effective and results in appropriate air exchange within the chest; and third, that the circulation is restored. These three aspects of basic CPR are prioritized in this sequence because the establishment of a functional airway must be the initial and primary concern.

A. **Airway maintenance.** In the obtunded or unconscious patient, the upper airway may become obstructed due to relaxation of muscle groups in the upper respiratory tract. Should upper airway obstruction by a foreign body be suspected, the airway should be cleared either manually or, if unsuccessful, by the Heimlich maneuver (performed by applying anterior chest thrusts to the lower abdomen with the patient in a supine position).

1. **When respiratory effort exists,** airway patency can often be obtained by a variety of simple mechanical maneuvers that involve the mouth, chin, and mandible. When injury to the cervical spine is not present, simply tilting the head backward may be dramatically effective in opening the airway, and if so, signs of respiratory obstruction, such as stridor, may disappear. In some patients, the insertion of an oral or nasal airway, provided that the former does not result in gagging or vomiting, followed by bag-mask–assisted ventilation as required, may provide adequate oxygenation while the physician attends to other aspects of CPR. In other patients with respiratory effort, the jaw thrust (which involves placing the fingers bilaterally behind the mandibular angles and displacing the mandible forward or anteriorly) or the chin lift may provide complete control of the upper airway. The jaw thrust, which results in little or no movement of the neck, is the preferred initial maneuver in patients with possible injury to the cervical spine. In all patients, supplemental oxygen should be administered.

   Despite respiratory effort by the patient, the use of supplemental oxygen, and the application of techniques to open the airway, patients with inadequate oxygenation urgently require establishment of a patent airway. Rapid sequence endotracheal intubation is the preferred maneuver; relative contraindications include potential injury to the cervical spine, mechanical upper airway obstruction, severe restriction of cervical spine mobility, severe perioral trauma, or an inability to open the patient's mouth, e.g., during seizure or associated with teeth clenching. In many such cases, nasotracheal intubation remains a valuable technique that may safely be used in the presence of contraindications to endotracheal intubation. In the patient with potential cervical spine injury, insertion of a nasotracheal tube while the cervical spine remains immobilized is both safe and effective. Nasotracheal intubation should probably be avoided in patients with significant maxillofacial trauma, since intracranial penetration along fracture lines has been reported. Because of a variety of factors, in some patients it may not be possible to obtain an airway by endotracheal or nasotracheal intubation. In these