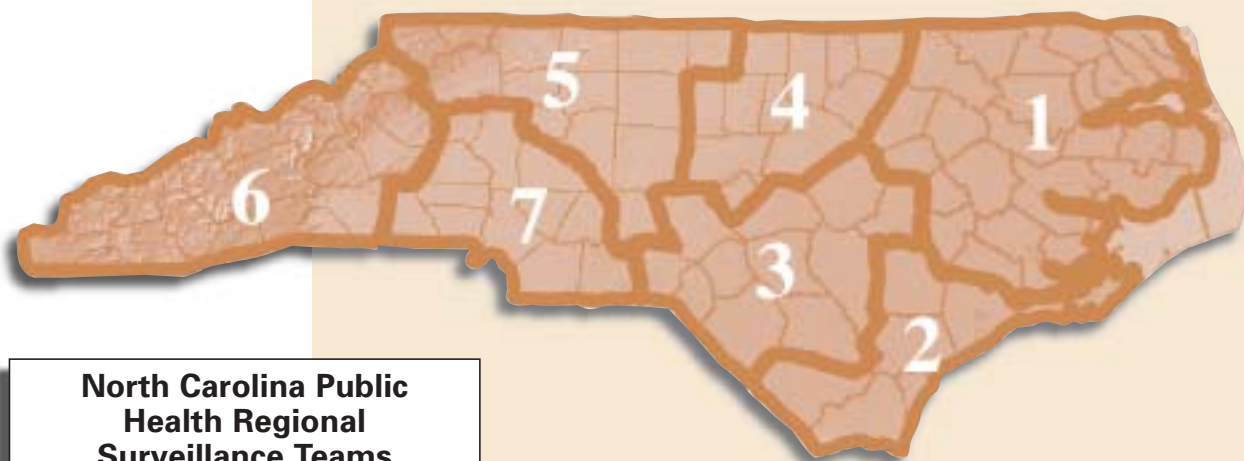


*Surveillance Teams*  
*Crew Member of the Year*  
*New Emergency Department*  
*Attendings*  
*Management of Splenic Injuries*  
*TIPS in Helping the Spanish*  
*Speaking Trauma Patient*  
*Outreach Corner & Calendar*

## *Surveillance Teams*

*by*  
*Emily E. Sickbert-Bennett, M.S.*  
*Disease Investigation Specialist*  
*NC Public Health Regional Surveillance Team*

# Duke LifeNet



**North Carolina Public  
Health Regional  
Surveillance Teams**

In response to the anthrax attack of October 2001 and continued threats of bioterrorism, an Office of Public Health Preparedness and Response in the Bioterrorism Branch was created within the Epidemiology Section of the Division of Public Health. In addition to the Office of Public Health Preparedness and Response led by retired Col. James W. Kirkpatrick, seven Public Health Regional Surveillance Teams (NC Public Health RSTs) were developed. These teams are a state resource that are hosted by a county health department where they serve a region of multiple counties at the request of a county and under the direction of the Office of Public Health Preparedness and Response.

Each NC Public Health RST is composed of a team leader, usually a physician/epidemiologist; a nurse epidemiologist/disease investigation specialist; an industrial hygiene/environmental health specialist; and an administrative assistant. These Regional Surveillance Teams will serve the

*(Continued On Page 3)*

*Duke Trauma Center*  
*Duke Life Flight*  
*Duke Emergency Department*  
*Duke Transfer Center*  
*Duke Disaster Planning*  
*Duke University Hospital*  
*Durham, North Carolina*

Duke Emergency Services

Changes in Emergency Services continue at Duke University Hospital. In addition to the new Emergency Medicine residency program, well underway, there have been many new hires in the Emergency Department, as Lisa Lewis' article highlights.



*Thomas Z. (Tim)  
Hayward III*

Also, the Trauma Service is happy to welcome Thomas Z. (Tim) Hayward III as a new faculty member in the Department of Surgery. Tim completed his general surgery residency at Duke and recently finished a Trauma/Critical Care fellowship at the R Adams Cowley Shock Trauma Center in Baltimore.

Just a reminder that emergency patient transfer requests to Duke should be initiated through the transfer center or LifeFlight, not the emergency room or individual MD. The transfer center number is (919) 681-3440 or toll free (800) 524-5433. One call by the referring physician to one of the above numbers does it all to facilitate transfers, so please keep these numbers posted in a convenient place in your emergency department.

*Steven N. Vaslef, MD, PhD  
Director, Duke Trauma Center*



*(left to right) Mary Anne Bosher, Barbara Willis,  
Ron Boatwright, and Mitch Babb.*

## Crew Member of the Year!!

by

*Mitch Babb, RN, BSN, CMTE  
Clinical Operations Director  
Duke Life Flight-Johnston Base*

Congratulations to Ron Boatwright, RN, CN III, from Duke Life Flight - Johnson Base, for winning the Crew Member of the Year Award, sponsored by American Eurocopter Corporation through the Association of Air Medical Services (AAMS). This award recognizes an individual or team who has demonstrated incredible ability under exceptional circumstances in the medical transport industry.

Key factors that contributed to Ron winning this award were his many certifications: BLS, ACLS Instructor-Regional Faculty, PALS, EMT-P, PHTLS, Hazmat Awareness Level Training, CEN, NC RN Licensure, NC EMS level II Instructor, and Crew Resource Management. There are also the committees he participates in: Staff Satisfaction, Preceptor, and Education and Public Relations Committees. Ron has also developed the Life Flight self study packet on Metabolic/Endocrine and Site specific orientation packet for

new hires. His most recent adventure has been to be one of the first to have a shared position in Life Flight, meaning he doesn't work only at one base, and has brought great success to this new venture.

Ron's experience is revealed in his overall global approach to patient and non-patient care factors. Ron's customer service, dependability, mutual respect, diversity and teamwork are one to be desired. Ron is a clinical expert and conducts himself in the utmost professional manner. He is self motivated, displays a positive attitude, pays attention to detail and is very thorough with his nursing practice. He is an individual of extremely high character and is respectful to anyone whom he comes in contact with. Ron is a tremendous asset to Duke Life Flight and it is a great honor to work with someone of this caliber in the health-care market.

Duke Emergency Services

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[www.dukehealth.org/emergency\\_services/trauma](http://www.dukehealth.org/emergency_services/trauma)

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## SURVEILLANCE TEAMS CONTINUED



*Smallpox: pustular rash  
(World Health Organization)*

public health, medical, and emergency response communities of each region by

1. providing **education and training** in epidemiological principles fundamental to recognition, investigation, and control of disease outbreaks.
2. improving **public health preparedness**
  - a. by assisting in the development and testing of county-wide public health plans for response to a biological, chemical or nuclear attack.
  - b. by carrying out vulnerability assessments for facilities that are potential targets of biological, chemical, or nuclear terrorism.
3. performing both **active and passive surveillance** for syndromes typically associated with bioterrorism agents (for example, Varicella infection in adults, unusual increase in influenza-like illness)
4. assisting in the **response to biological, chemical or nuclear attacks** at the request of the local health department.
  - a. by assisting in outbreak investigations of bioterrorism poten-

### Contact your Regional Surveillance Team:

<b>Region 1</b>	<b>252-413-1446</b>
<b>Region 2</b>	<b>910-343-6760</b>
<b>Region 3</b>	<b>910-433-3821</b>
<b>Region 4</b>	<b>919-560-7891</b>
<b>Region 5</b>	<b>336-641-8190</b>
<b>Region 6</b>	<b>828-250-6104</b>
<b>Region 7</b>	<b>704-432-1971</b>

tial or other communicable disease outbreaks that may overwhelm local resources.

b. by offering consultation regarding exposure assessment and appropriate decontamination procedures

## New Emergency Department Attendings

by:

*Lisa S. Lewis, R.N.*

This fall, a dozen new attending physicians have joined the Emergency Department staff at Duke. In addition to patient care, they will participate in the Emergency Medicine Residency program as instructors.

While most of the doctors treat children and adults, three have been hired exclusively as pediatricians: William C. Bordley, M.D., Sara Page Robert, M.D., and Stephen Becket Leinenweber, M.D. Dr. Leinenweber comes to us following a fellowship in

pediatric critical care here at Duke. He will divide his time between the Emergency Department and the PICU as well as his research on traumatic brain injury.

Part-time physicians hired include Catherine Myers, M.D. and Daniel Booth, M.D. Dr. Booth grew up in the Durham area, graduated from Duke Medical School and left to practice in Fort Meyers, FL. He is happy to return to Duke and North Carolina.

Other names you will hear in the ER are Lee S. Benjamin, M.D., Michael B. Hocker, M.D., Miha Lucas, M.D., David E. Marcozzi, M.D., Ronny Otero, M.D., Traci Thoureen, M.D., and Sandra Moreira, M.D. According to Dr. Kathleen Clem, Chief of Emergency Medicine, the final hire will be Gabriel Reyes, M.D. arriving in October.

# Management of Splenic Injuries

by  
 Steven N. Vaslef, MD, PhD  
 Associate Professor of Surgery  
 Director, Trauma Services  
 Duke University Medical Center

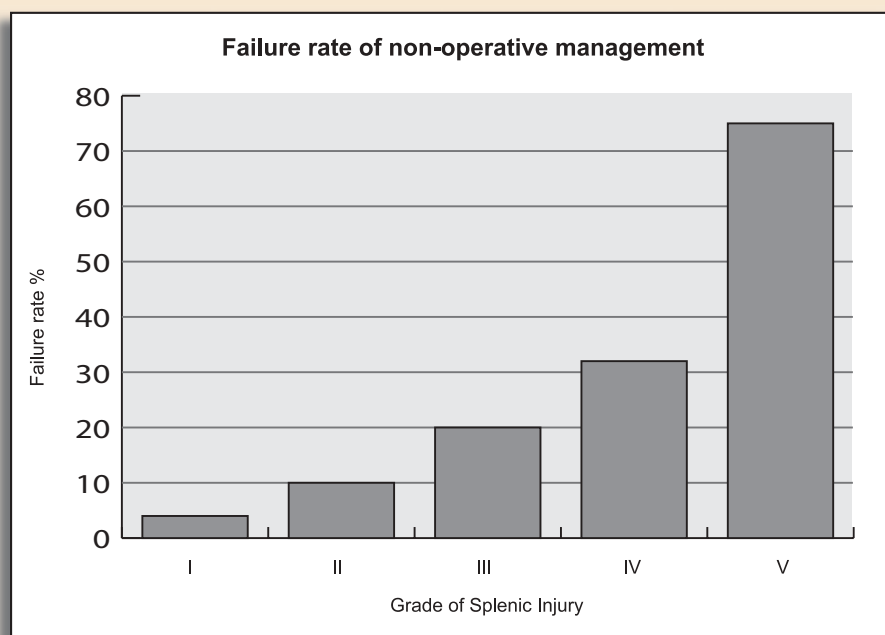
The spleen is the most commonly injured organ in blunt abdominal trauma. Nevertheless, non-operative management of the injured spleen has become the standard of care in many instances, with the goal of being splenic salvage. The spleen does have immune functions, and the asplenic state following splenectomy does carry a lifelong risk of increased infections. While the mortality risk of overwhelming post-splenectomy infection (OPSI) following trauma is thought to be less than 0.5%, the risk of potentially life-threatening infections, such as pneumonia, in asplenic individuals may be several hundred-fold that in the general population. Thus, the focus to save the spleen, when safe and possible, seems justified.

Our approach to the management of splenic injuries seen at Duke University Hospital is illustrated in the algorithm below. Grading the severity of the splenic injury is fundamental and should be done by computed tomogra-

phy (CT). The American Association for the Surgery of Trauma (AAST) grading system is employed to assign a Grade I through V, depending on the CT appearance of the spleen. Hemodynamic instability, ongoing transfusion requirement, or other indication for laparotomy mandates operative management of the splenic injury, either splenectomy or splenic repair. Also, a Grade V injury, or totally shattered spleen, is operated on, regardless of initial hemodynamic status, because of the high failure rate of non-operative management. The remaining splenic injuries are considered for non-operative management, which includes telemetry, serial hematocrit determinations and frequent abdominal exams for a 48 to 72 hour period. This is done in a stepdown unit for lower grade injuries (I and II) or in the Surgical Intensive Care Unit for grade III and IV injuries. Additionally, angiographic embolization by interventional radiolo-

gy is useful if a pseudoaneurysm or a “vascular blush” is evident on the CT scan. Studies have documented an increased success rate of non-operative management in such instances when angio-embolization has been used. Patients who require more than 2 units of red cell transfusions are considered failures of non-operative management and proceed to laparotomy.

Successful non-operative management of splenic injuries does consume significant hospital resources, but these patients do need to be watched closely for signs of delayed bleeding. Furthermore, these patients should be counseled that there is a defined risk of future bleeding that may require surgery. The multi-institutional (retrospective) study of the blunt splenic injuries in adults, conducted by the Eastern Association for the Surgery of Trauma, provides us with the best data to date regarding the success and failure rates of non-operative management (J Trauma 2000;49: 177-189). Of 1488 adult trauma patients with blunt splenic injury from 27 trauma centers, 38.5% went directly to laparotomy and 54.8% were ultimately successfully managed nonoperatively. Of note, 10.8% of patients admitted with planned observation failed and required laparotomy. Most failures, 60.9%, occurred in the first 24 hours, but occasional failures did occur beyond the first week. Not surprisingly, the failure rate of non-operative management was related to the grade of injury, as shown in the graph on the left:



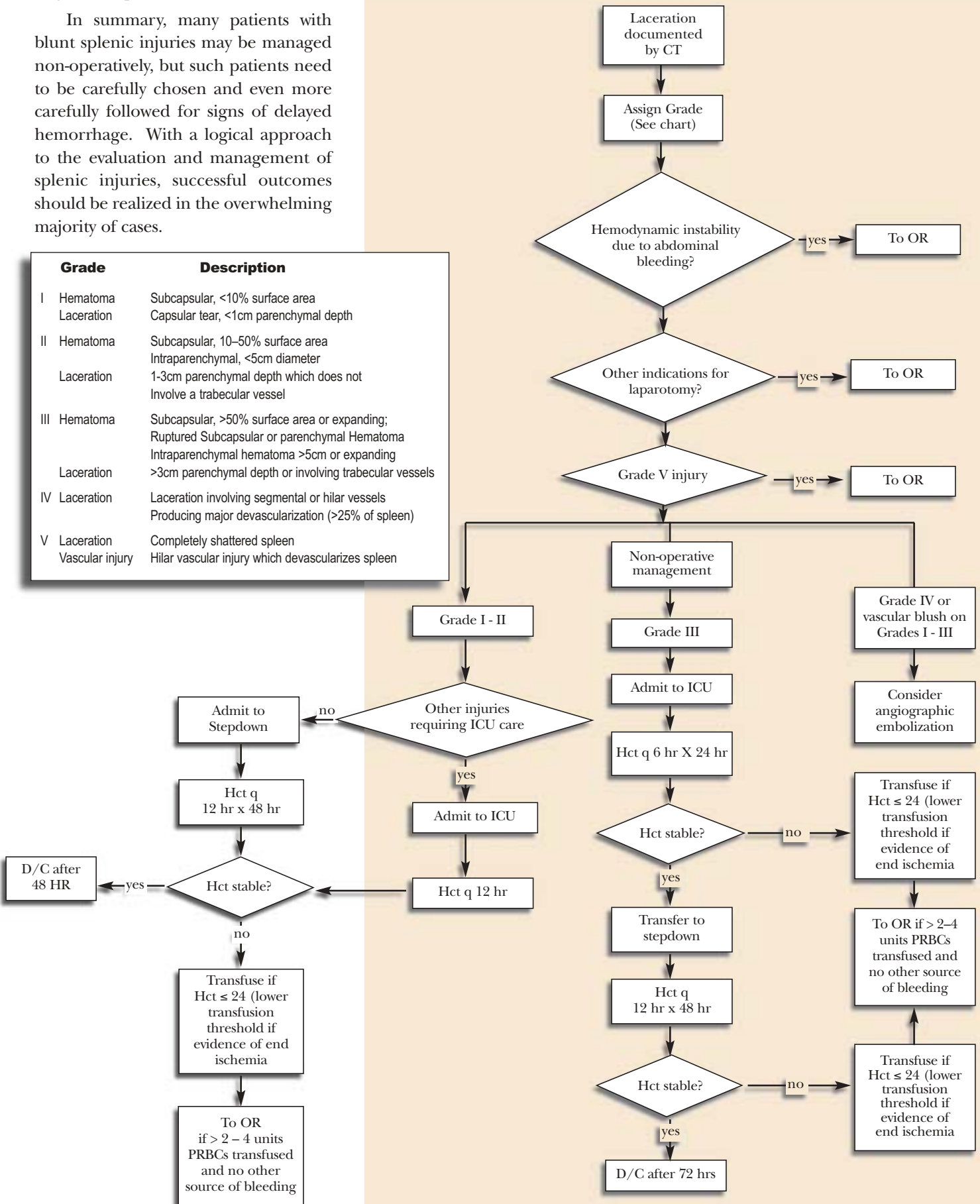
We do not routinely obtain follow up imaging studies of the spleen prior to discharge or in the clinic. Patients with splenic injuries are advised to refrain from strenuous activity and con-

tact sports for a period of three months to give the spleen time to heal.

In summary, many patients with blunt splenic injuries may be managed non-operatively, but such patients need to be carefully chosen and even more carefully followed for signs of delayed hemorrhage. With a logical approach to the evaluation and management of splenic injuries, successful outcomes should be realized in the overwhelming majority of cases.

## Management of Splenic Lacerations

Grade	Description
I Hematoma Laceration	Subcapsular, <10% surface area Capsular tear, <1cm parenchymal depth
II Hematoma Laceration	Subcapsular, 10–50% surface area Intraparenchymal, <5cm diameter 1-3cm parenchymal depth which does not involve a trabecular vessel
III Hematoma Laceration	Subcapsular, >50% surface area or expanding; Ruptured Subcapsular or parenchymal Hematoma Intraparenchymal hematoma >5cm or expanding >3cm parenchymal depth or involving trabecular vessels
IV Laceration	Laceration involving segmental or hilar vessels Producing major devascularization (>25% of spleen)
V Laceration Vascular injury	Completely shattered spleen Hilar vascular injury which devascularizes spleen



# TIPS in Helping the Spanish Speaking Trauma Patient

by  
Rebecca Reyes, M.Div., MSW

The care and treatment of the trauma patient is complicated, intense, and can last for months. When one adds the variables of culture and language, the care and treatment of the trauma patient becomes even more challenging. Trauma statistics in North Carolina tell us that the Latino/ Spanish speaking patient is being seen more often in our emergency departments, trauma centers and life flight operations. You, the provider, need to respond quickly and effectively and information is key. Hopefully some of this information will help you with better understanding of and communication with the Latino/Spanish speaking patient. One reminder, the Latino/Hispanic individual represents a particular culture. In North Carolina, the majority of Latinos come from Mexico but there are diverse cultures and practices within Mexico and the other countries in Latin America.

## IDENTIFICATION: MI NOMBRE ES?

The Latino person's name will vary in construct depending on how recently

he has immigrated. For example, I am Latina. However, having lived in this country for at least four generations, my name structure is that of the dominant culture: a first name, a middle name and a last name. Most immigrants from Latin and South American countries use a different name structure. That structure consists of a first name, middle name, father's last name, and mother's last name.

Let's look at an example, that of a woman whose name is Maria Martha Reyes Gomez. Maria is her first name. Martha is her middle name, Reyes is her father's name, and Gomez is her mother's name. Let us say Maria gets married to Roberto Luis Guzman Leon. The married name for Maria would be Maria Martha Guzman Reyes. The woman takes her husband's name and keeps her father's last name. If she has children, her children will have their father's last name and their mother's last name.

It may be that you do not have the luxury of talking to the patient directly to confirm his/her name. If so, it is

important that identification be done via a family member, or by looking at some official identification like a driver's license or work identification card.

## DECISIONS: IT'S A FAMILY AFFAIR

One behavior that can frustrate providers who do not understand the underlying reason is the apparent non-compliance or hesitancy on the part of the patient or the family accompanying the patient. The patient appears to be reluctant to give permission for a medical procedure or treatment.

In the Latino culture decisions are very important and rarely made in isolation. Decisions about health care are extremely important; therefore the family is typically included in the decision making process. Even life threatening decisions can be postponed until the family is consulted and informed. Family is not confined to parents, but often times includes siblings, in-laws, and grandparents. This means the family present in the emergency room may want to contact the rest of the family in the country of origin, especially if the parents are living outside the United States.

## INTERPRETERS: HABLAS INGLES?

If a patient does not understand English, the use of an interpreter is critical and mandatory. Federal legislation, Title VI, mandates that an interpreter be used when a patient does not speak English. This is not optional. It is the law. An interpreter is one that has been trained in both medical language and the mechanics of triad interpretation.. It is illegal to use a family member, friend, and acquaintance as an interpreter. If an interpreter is not available use the ATT language line to assist the patient.

(Continued On Page 8)

## Join Duke Life Flight!

Duke Life Flight is a comprehensive air/ground critical care transport program with bases in Lumberton, Smithfield, Burlington, and Durham North Carolina. The program is currently seeking RN's and EMT Drivers to join our team! **RN Requirements include:** 3 years of current ICU/ED experience and the ability to work in a diverse autonomous environment, satisfactory completion of physical fitness standards, ACLS, PALS, and PHTLS/TNCC preferred, maximum weight 257lbs, and a 2-year minimum commitment to the program. Rotating 12-hour shifts available. **EMT Driver Requirements include:** 2 years of EMT experience, current North Carolina EMT certification, 25 Years of age, satisfactory completion of physical fitness standards, and a 2-year minimum commitment to the program.

If you are interested and would like to learn more about Duke Life Flight, contact one of the Clinical Operations Director nearest you!



Mitch Babb, Clinical Operations Director,  
Life Flight Johnston (Smithfield, NC)  
Office: 919-989-6814  
Email: [babb0003@mc.duke.edu](mailto:babb0003@mc.duke.edu)

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Email: [boshe001@mc.duke.edu](mailto:boshe001@mc.duke.edu)

Robyn Wood-Nobblitt, Clinical Operations Director,  
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Office: 336-584-7140  
Email: [woodn002@mc.duke.edu](mailto:woodn002@mc.duke.edu)

Barbara Willis, Clinical Operations Director,  
Life Flight Lumberton (Lumberton, NC)  
Office: 910-738-4292  
Email: [willi087@mc.duke.edu](mailto:willi087@mc.duke.edu)



## Outreach Corner

By *Ginger G. Wilkins, RN, BSN*

Greetings everyone, hope you all had a safe and relaxing summer. I have had the opportunity to make it to all of our primary RAC hospitals as well as the EMS/EM facilities in your county. I appreciate all the tours and introductions. I'm getting better all the time at matching names and faces! I'll be by to see you all at least quarterly.

Thanks to all of you who were able to attend the July RAC meeting. I know it's sometimes hard to work it in around summer vacations and other commitments. We are finalizing the structure of the combined Duke/Mid-Carolina Disaster Planning/Bioterrorism Committee. Our first joint meeting will be held before the next RAC meeting. Fred Brown is the consultant we have hired to lead this group. With his help and input, I know that we can move toward fulfilling the mission of this committee which is to ensure that in the event of an epidemic or a bioterrorist incident, all citizens of North Carolina will have access to the medical care services they need and to prevent the further spread of disease and to strengthen disaster preparedness at regional and local levels.

As we gear up and get our Disaster Preparedness/BT Committee up and running, I want to encourage you all to continue your involvement in the other

committees. The Education, Legislative, PI, and Care Management committees are the "nuts and bolts" of the RAC and we must move forward and be productive to fulfill the requirements of our by-laws. We've had several volunteers recently to head up committee work, any of you that are interested will not be turned down. Claudia and I will work with you in any way we can to support and sustain our committees.

If anyone is interested in hosting the quarterly RAC meeting in your area, please contact me. We would be more than happy to come; I know that it's not always that convenient to travel all the way to Durham from where you are. Also, don't hesitate to call or e-mail me with any educational needs or concerns regarding trauma care issues. If I can't help you myself, I'll find the right person for your hospital or EMS system.

*Take care and stay safe,*

Ginger

## Outreach Calendar

### November

- 6 & 7 PHTLS Course**  
**Contact: John Duskey**  
**(919) 684-2197**
- 12 State EMS Advisory Council Meeting**  
**Contact: Sharon Rhyné**  
**(919) 855-3951**
- 14 Trauma of Terror**  
**Contact: John Duskey**  
**(919) 684-2197**
- 15 & 16 ATLS Course**  
**Contact: John Duskey**  
**(919) 684-2197**

### December

- 3 Trauma Stabilization Course**  
**Contact: John Duskey**  
**(919) 684-2197**
- 4 Pediatric Trauma**  
**Contact: John Duskey**  
**(919) 684-2197**
- 13 Geriatric Trauma**  
**Contact: John Duskey**  
**(919) 684-2197**

### January, 2003

- 31 Duke RAC Meeting**  
**Contact: Ginger Wilkins**  
**(919) 684-0140**

### March

- 13 13th Annual Duke Trauma Conference**  
**Contact: John Duskey (919) 684-2197**

## SPANISH SPEAKING TRAUMA PATIENT CONTINUED

### CAUSE OF ILLNESS

Some Latinos believe that illness is a punishment or caused by God. This belief system can influence the response of the patient to the treatment plan. It is not unusual for the Latino patient to depend much on prayer and spiritual direction for healing. The patient may appear depressed or despondent, but in reality he/she might just be accepting God's will. One example of this belief system is "mal de ojo", or the evil eye. In children, it is thought to cause vomiting, fever, crying and restlessness. It is believed to be brought on by an admiring look from a person. In the Latino community it is treated with a barrida- a sweeping of the body with eggs, lemons, and bay leaves, accompanied by prayer. The intervention of a spiritual guide is significant in the treatment of these diagnoses. The . "The Latino patient may also be open to speaking with a hospital chaplain so ask the patient if he/she wish to see a chaplain. The

chaplain can be a great asset in empowering the patient to become more active in his/her treatment plan.

### USE OF OTHER MEDICAL PROVIDER:: TIENE USTED UN CURANDERO?

In most Latino communities there is a healer called a curandero/a. This person is recognized by the Latino community as someone who can restore health to the body. The healer uses teas, herbs, massages and other remedies to assist the patient in healing. The Latino patient might use this healer, in collaboration with the treatment plan of the medical physician. Do not hesitate to inquire of the patient if he or she is using any other remedies for the illness.

### LEGAL STATUS: ES USTED DEL LOS ESTADOS UNIDOS?

Providing medical care to the patient is the first priority. Remember -

care is not dependent on citizenship. Along this line, patients and family who are from another country might feel intimidated due to the presence of police, or other legal authorities present in the emergency room. Many patients who are immigrants or who do not have legal documents fear deportation and interrogation. It is important to provide a safe atmosphere for Latino patients and their families. Many patients will avoid receiving medical care due to fear of being deported or reported to the INS.

*The director of the Latino Health Project is Muki Fairchild.*

*For more information on the Latino community or patient care you can call Rebecca Reyes, project coordinator for the Latino Health Project, 668.2193.*

Duke Emergency Services

# Duke LifeNet

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