

# AEROMED OUTREACH

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## TGH BRANDON HEALTHPLEX OPEN HOUSE

Aeromed recently participated in the Tampa General Hospital Brandon Healthplex open house. The event celebrated the opening of the Emergency Department at the Healthplex on March 27th. Additional services to open in the near future include ambulatory surgery, lab and imaging services and a pharmacy.

The Brandon Healthplex will also have offices for TGMG primary care physicians, USF specialty physicians and Brandon area community

physicians. It also will include a helipad.

The open house event included new facility tours, helicopter tours and free activities like face painting and fun photo booth. The Tampa Bay Rays, the Tampa Bay Lightning, Topgolf, iFly indoor skydiving and the American Heart Association also set up booths.



**UPCOMING OUTREACH ACTIVITIES**

- **Aeromed Community Education Session May 4th at 0900. Contact Jennifer Mefford at [jmefford@tgh.org](mailto:jmefford@tgh.org) for more information.**

## THE GUY EXPO 2017

Aeromed recently participated in the annual men's health event in Manatee County. The GUY Expo was held at the Bradenton Area Convention Center and was all about fun while caring for your health. During this event, health screenings, educational presentations and consultations were

available for free.

Also included was the "Save A Life Tour" that stresses the risk of death and injury associated with distracted driving, sponsored by Blake Medical Center, and helicopter tours by Aeromed.



## PHYSICIAN'S ARTICLE

**Wolff-Parkinson-White Syndrome**

We have discussed Wolff-Parkinson-White (WPW) syndrome in the past. But, I feel, it is appropriate to review complex concepts to ensure understanding. This is true especially when certain treatments we provide in the field or hospital can cause significant harm to the patient if done incorrectly.

Estimated to occur in 0.1% to 0.3% of the population, WPW is a condition in which atrial impulses bypass the atrioventricular (AV) node and activate the ventricular myocardium directly through an accessory pathway. Although several different rhythm presentations are possible, atrial fibrillation (a-fib) is a frequent dysrhythmia seen in the WPW patient. A-fib with WPW should be suspected in an EKG that shows an irregularly irregular rhythm with QRS complexes that have changing morphologies and ventricular rates that approach

300 beats per minute.

This is different from a-fib with aberrancy (i.e., right or left bundle branch blocks). In the setting of a-fib with aberrancy, the rhythm is also irregularly irregular but the QRS morphologies will be the same/unchanging, and the rates will not be excessively fast. Stable patients suspected of having a-fib with WPW should not receive agents that block the AV node, such as calcium channel blockers (CCB) or beta blockers. The administration of AV nodal blocking medications will allow all of the atrial impulses to go down the accessory pathway. Keeping in mind that the atrial rate in a-fib is upwards of 600 bpm, allowing unrestricted conduction down the accessory pathway during a-fib will lead to ventricular fibrillation. This is certainly not the outcome we are looking for when simply attempting rate control in a stable patient. These stable patients are treated with either procainamide

or ibutilide. If unstable, as with any other unstable tachydysrhythmia, they are treated with synchronized electrical cardioversion. Electricity!!

It is my opinion that we should not use AV node blocking agents in the field for a-fib. Take a step back and consider the risks and benefits. A stable a-fib patient with rapid ventricular response (RVR) does not require rate control emergently. Sure, they should receive rate control somewhat quickly as we don't want an 85 year-old's heart racing at 140 bpm for 2 days. But a 15 minute transport won't make much difference if he is stable. If he is unstable he should receive immediate synchronized cardioversion. If the patient is in a-fib with WPW, the potential for harm is great if we do not recognize the condition. The amount of harm we can do in that situation versus the amount of good we do by achieving rate control in a-fib RVR, in my opinion,

is not worth the risk. Remember electricity is your friend. If a patient with a-fib is unstable he should receive synchronized electrical cardioversion. If the patient is stable I believe we should hold AV node blockade until the patient is in a more controlled hospital setting.

Most of the above is only my opinion. As always, follow your protocols. I am an advocate of EMS and do not intend to imply that prehospital providers cannot assess these patients properly. But I feel that management of stable a-fib patient may be safer in the hospital setting. Please email with other opinions or questions.

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