



RESIDENT PRESIDENT'S MESSAGE

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During my presidency, I have written a number of articles regarding a variety of topics. The common theme to all of them is that it is important as a future or present emergency medicine physician to become involved in advocacy in one form or another. This is why I initially became involved in the AAEM/RSA and why I have urged others to do so.

I recently attended AAEM's Scientific Assembly in Amelia Island. It was heartening to see how many residents and students are interested and informed regarding the preeminent issues facing the practice of emergency medicine. The importance and implications of AAEM's corporate practice of medicine litigation in Texas against TeamHealth, challenges to who can be considered board certified and the recent changes in policy of ACEP to allow non-board certified individuals to become fellows, are all issues that were discussed, among many more. There was a real passion in the debate regarding these issues. This passion is where good, strong advocacy starts.

As many of you are reading this, you most likely recently found out where you will be attending residency starting this June. I urge you to become involved outside of your residency. Our current board is comprised of four members that were serving their term as first year residents. They brought fresh ideas and enthusiasm to their positions, probably, in part, because they became involved so early in their career. In return, I believe they obtained knowledge and experience regarding the bigger picture of emergency medicine than we are often privy to when we stay within the confines of our residencies.

So, my message is simple; become involved. Become involved early. Learn as much as you can. And, pardon me for being partial, but join AAEM/RSA to achieve this. Remember, FAAEM *always* means board certified. With the exception of the founders of our specialty who became practice-eligible, board certified should ALWAYS mean emergency medicine residency trained.

Resident Journal Review: November – December 2007

This is a continuing column summarizing journal articles pertinent to EM residents. It is not meant to provide an extensive review of the articles nor is it wholly comprehensive of all the literature published. Rather, it is a short list of potentially useful literature that the busy EM resident may have missed. Residents should read the articles themselves to draw their own conclusions. This edition will include articles published over a two month period. These selections are from papers published in November and December 2007.

-David Wallace, MD MPH; Daniel Nishijima, MD; Christopher Doty, MD and Amal Mattu MD

Onalan O, Crystal E, Daoulah A, Lau C, Crystal A, Lashkevsky I. Meta-analysis of magnesium therapy for the acute management of rapid atrial fibrillation. The American Journal of Cardiology 2007;99:1726-32.

This meta-analysis studied the use of magnesium sulfate for the acute management of atrial fibrillation with rapid ventricular rate. The primary outcomes analyzed were success in achieving rate control, rhythm control or both. Secondary outcomes were the time to a response and the risk of a major adverse effect. The final analysis used eight trials for rhythm control and seven trials for rate control. The total administered magnesium in trials ranged from 1.2 to 10 grams, with an initial dose of 1.2 to 5 grams given over 1 to 30 minutes.

The study design was not uniform in its comparison of magnesium sulfate therapy to placebo or standard care; however, several patterns were suggested by the Forrest plots. Magnesium was more effective than the control group for rate control (pooled OR 1.96, 95% CI 1.24 – 3.08), rhythm control (pooled OR 1.6, 95% CI 1.07 – 2.38) or either rate or rhythm control (pooled OR 4.61, 95% CI 2.67 – 7.96). Individual studies showed similar reductions in ventricular rates comparing magnesium to diltiazem or amiodarone.

This study supports further investigation into the use of magnesium sulfate for the acute management of atrial fibrillation with rapid ventricular rate. Magnesium is safe, inexpensive and widely available in emergency departments. In cases of atrial fibrillation that are difficult to control using conventional therapy, intravenous magnesium should be considered as another therapeutic option. More research is needed to explore its use as an adjunctive agent to existing pharmacotherapy, as large well-conducted trials are currently lacking.

Gupta K, Hooton TM, Roberts PL, Stamm WE. Short-course nitrofurantoin for the treatment of acute uncomplicated cystitis in women. Arch Intern Med 2007;167:2207-12.

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