Cancer sucks! This is the proverbial phrase that unites all cancer survivors, cancer fighters, and cancer victims. It allows unity among the terrifying cancer experience, allowing us to bond and empathize over the seriousness that is a cancer diagnosis. Clinical experience suggests that cancer is frequently diagnosed in the emergency department (ED). Anecdotally, in three years of residency I have seen a whopping two STEMI’s between my two large academic EDs, whereas, maybe monthly I worry about a new cancer diagnosis.

Some studies have demonstrated that patients diagnosed with cancer in the ED have more advanced disease and poorer outcomes when compared to outpatient diagnoses. Of the estimated 105,000,000 emergency department (ED) visits annually, almost 4,000,000 (3.8%) are that of cancer patients. Knowing the impact of cancer-related illnesses is research that is ongoing, but little is known about the rate of new-onset cancer diagnoses in the ED.

Compared to non-cancer patients, ED patients are older, experience longer ED length of stay, undergo radiological testing (including CT scans), more likely to be septic, have higher thrombosis rates, and are more likely to be admitted to the hospital. Thus, the ED presents as a unique interface for the large number of potentially sick cancer patients. Of the cancer visits, ED providers frequently see oncological emergencies such as febrile neutropenia, acute pain, shortness of breath, and spinal cord compression. Further, as patients get closer to the end of their life, ED utilization increases. How do we identify patients with malignancy sooner as to prevent some of the significant downstream complications of more advanced disease states?

Further, some recent, but limited work has shown patients diagnosed in the ED with some sort of suspected malignancy suffer worse outcomes, theoretically due to more advanced disease states. Seemingly this is a vulnerable patient population and by accomplishing this preliminary work we can impact a large population of patients. A lot of these patients visit the ED before they are diagnosed with cancer, and by identifying which types of malignancies most commonly are diagnosed in the ED, and in which subset of patients present with these malignancies, protocols can be made to identify these patients earlier. For better or for worse the ED is the safety net for a large population, and while the ED isn’t designed for primary care for many hospitals the ED is the entrance to the hospital but more importantly the health care system.

There is certainly little evidence about who and why we diagnosis with cancer but it happens. It happens everyday in all EDs across the nation. CNN highlighted this idea in that we are seeing cancer diagnosis made in younger and younger patients, further emphasizing that cancer sucks, and even more ED physicians need to be on the look out for malignancy.

We are trained in emergent diagnoses, hyperkalemia, stroke, STEMI, and septic shock, but in reality we do more than that. I would argue we practice as much primary care and non-emergent care as we do emergent, and appreciating the impact of one single cancer diagnosis has on a patient, a family, a community is of tremendous importance.

Rather than scuff off at the opportunity to be a patient’s doctor, don’t just say “they can follow up with their PCP” but instead tell the patient what you are worried about. Use the word cancer. Be honest, be fair, and be there for your patients. Remember, cancer sucks and we need to be there for our patients.
Join an AAEM/RSA Committee!

Wellness Committee
Committee members will focus on resident and student wellness initiatives including taking on new initiatives like creating a wellness curriculum and identifying the unwell resident and/or student. Committee members will act as liaisons to the AAEM Wellness Committee in helping to plan activities for the annual Scientific Assembly that enhance their vision of making Scientific Assembly a rejuvenating wellness experience for EM physicians, residents, and students.

Advocacy Committee
Committee members staff three sub-committees, focusing on patient advocacy, resident advocacy and political advocacy both at the state and national levels. Your activities include developing policy statements, outreach to AAEM/RSA members about critical issues in emergency medicine, and collaborating with the AAEM Government Affairs Committee.

Diversity & Inclusion Committee
Committee members will work with the AAEM Diversity and Inclusion Committee outreach to underserved medical schools, and create resources for minority residents and students in emergency medicine.

Publications and Social Media Committee
The Social Media Committee members will contribute to the development and content of RSA’s four primary media outlets: the RSA Blog Modern Resident, the AAEM/RSA website, Facebook and Twitter. The committee also oversees development and revisions of AAEM/RSA’s multiple publications including clinical handbooks and board review materials. You will have numerous opportunities to edit, publish, and act as peer-reviewers, as well as work from the ground-up in developing AAEM/RSA’s expansion to electronic publications.

Education Committee
Committee members plan and organize the resident educational track at the AAEM Scientific Assembly, which will be held April 19-23, 2020 in Phoenix, AZ. You will also assist with the medical student symposia that occur around the country.

International Subcommittee
The International Committee will have the opportunity to contribute to international medicine projects and resource development that are helpful and beneficial to students and residents.

References

Apply Today: www.aaemrsa.org/get-involved/committees