

## EMCORE Melbourne 2017

EMCORE Melbourne is a 2 day event of INTERACTIVE Lectures that equip doctors with essential knowledge in the essential areas of medicine that relate to everyday practice.  
Areas include: Resuscitation, Trauma, Cardiology, Paediatrics, Neurology, Obstetrics and Gynaecology, Infectious Diseases, Interpretation of labs and more.

The lectures are delivered by specialists in Emergency Medicine.

Total Conference Time 13.25 hours.

The conference Has been awarded 40 Cat 1 points by RACGP in the past. It meets the domains of professional knowledge

### **SATURDAY**

**Chair**                      **Peter Kas**  
0830-0845      Introduction: The Hero Has a Thousand faces *Peter Kas*  
0830-0900      Resus I: Cardiac Resus *Luke Lawton*  
0900-0915      Resus II: Paediatric Resus *Arjun Rao*  
0915-0930      Resus III: Trauma Resus *Peter Kas*  
0930-0945      Facial Injuries *Luke Lawton*  
0945-1000      The Trauma Airway *Luke Lawton*  
1000-1015      Traumatic Vascular injuries *Will Davies*  
1015-1030      Trauma and Pregnancy *Sam Bendall*

1030-1100      *BREAK*

**Chair**                      **James Edwards**  
1100-1115      Hand Injuries *Michael Sheridan*  
1115-1135      Kids don't Bounce: Paediatric Trauma *Claire Wilkin*  
1135-1145      Traumatic Head Injury: Mannitol anyone? *Peter Kas*  
1145-1150      Ocular Trauma *Will Davies*  
1150-1200      Dental Trauma *Alastair Meyer*  
1200-1215      Drunk, Threatening Trauma patient, wants to leave. Can I let them? *Michael Sheridan*  
1215-1245      Caring for the Patient That Wants to Harm You *Jonathan Knott*  
1245-1300      Trauma Resuscitation Live *The CoreTeam*

1300-1400      *LUNCH*

**Chair**                      **Will Davies**  
1400-1425      Headache I: Sudden Headache: Now What? *Kevin Chu*  
1425-1440      Headache II: Not Subarachnoid: Are we done? *Peter Kas*  
1440-1450      Headache III: VP Shunt; Now What? *Pascal Gelperowicz*  
1450-1500      Headache IV: Subdural/Extradural: Now What? *Adam Michael*  
1500-1515      Resistant Status Epilepticus? Get the Ketamine! *Peter Kas*  
1515-1530      Intracranial Bleed/ SAH: How to Maximise Management *Peter Kas*

1530-1600      *BREAK*

**Chair**                      **Peter Kas**  
1600-1610      Head Injury, on Anticoagulants: Do I need to Scan Twice? *Alastair Meyer*  
1610-1615      Mechanical Valve, on Anticoagulants, New Intracranial Bleed: Now What? *Michael Sheridan*  
1615-1625      Anticoagulated and needs an LP/Chest Tube: Now What? *Will Davies*  
1625-1630      NOAC: Which to Use and When. *Will Davies*  
1630-1635      5 in 5: 5 papers that may or may not change your practice *Peter Kas*  
1635-1645      Dissecting the Paper *Gino Toncich*  
1645-1700      Get Me Outa Here: Retrieval Medicine *Sam Bendall*

## SUNDAY

**Chair** **James Edwards**  
0830-0845 Awake Intubation; The Prodigal Son Returns [Peter Kas](#)  
0845-0915 Everything .....About Procedural Sedation,But were Afraid to Ask [Greg Treston](#)  
0915-0930 The Paediatric Airway [Peter Kas](#)  
0930-0945 ED Crash Intubation [Greg Treston](#)  
0945-1000 BiPAP:Use it Like a Pro [James Edwards](#)  
1000-1005 High Flow Oxygen in Kids [Arjun Rao](#)  
1005-1020 Bronchiolitis, Asthma and Croup: Treat Them the Same?[Claire Wilkins](#)  
1020-1030 Airway Live Demonstration [The Core Team](#)

1030-1100 BREAK

**Chair** **Peter Kas**  
1100-1115 RASHES QUIZ: Rashes to Know: Real Time Answering [Will Davies](#)  
1115-1130 ALTE by Any Other Name, Is it Still ALTE? [James Edwards](#)  
1130-1140 The Bilirubin Baby [James Edwards](#)  
1140-1205 SIC KID 2017: Where Are We Now? [Peter Kas](#)  
1205-1215 Paeds Pearls [Peter Kas](#)  
1215-1225 The Discrimination Zone [Adam Michael](#)  
1225-1235 PV Bleed and Hypotension [Adam Michael](#)  
1235-1245 Is it Hyperstimulation Syndrome? [Adam Michael](#)  
1245-1300 PV Bleeding and bHCG negative [Adam Michael](#)

1300-1400 LUNCH

**Chair** **Will Davies**  
1400-1420 Seizure Syncope and Sudden Collapse [Peter Kas](#)  
1420-1435 Arrhythmias: Rule the Resus Room [Live demonstration Peter Kas](#)  
1435-1450 The Shocking Facts about ED Cardioversion [Greg Treston](#)  
1450-1510 Making the Management of Stimulants Crystal Clear [Zeff Koutsogianis](#)  
1510-1530 Venom Toxicity [David Williams](#)  
1530-1540 10 ECG's in 10 Minutes: What the Bootcamp people learnt. [Peter Kas](#)

1540-1610 BREAK

**Chair** **Peter Kas**  
1610-1620 Outpatient Management of PE [James Edwards](#)  
1620-1630 Is Contrast Nephropathy Real? [James Edwards](#)  
1630-1640 Can I give that by I/O? [Will Davies](#)  
1640-1650 Hyponatraemia Diagnosis [Peter Kas](#)  
1650-1700 Hypertonic Saline? Why Not? [Peter Kas](#)  
1700-1715 SEPSIS 2017: Promise, Process, Arise [James Edwards](#).

Education Activity developer for this activity	Name <b>Dr Peter Kas</b>	EAR reference no [REDACTED]
Provider/organisation	Name <b>Soma Health</b>	Provider no <b>590778</b>
	Address <b>level 2, 710 Collins Street Docklands, Vic. 3008</b>	
Contact for admin and/or registration enquiries	Name <b>Dr Peter Kas</b>	Phone <b>0413847121</b>
	Email <b>drpeterkas@gmail.com</b>	
Name of GP(s) involved in the planning/development of this activity	Name <b>Dr Jean Claude Huynh</b>	Qualification <b>MBBS</b>
	RACGP QI&CPD no <b>534711</b>	Phone <b>0414977446</b>
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Sponsor organisations involved in this activity	Name [REDACTED]	
	Details [REDACTED]	
Other organisations involved in this activity	Name [REDACTED]	
	Details [REDACTED]	
Title of module	<b>coreEM</b>	
This module will be	<input type="checkbox"/> A one off event (run once only) <input checked="" type="checkbox"/> A repeated activity (identical activity repeated at different times and/or locations) <input type="checkbox"/> Regular activity e.g.: monthly meetings <input type="checkbox"/> Continuous education e.g. online	
Total structured learning activity hours of the module	<b>13</b>	Do not include time for breaks, meals, trade displays, or completion of predisposing & reflective activities. Activity must be a minimum of 6 hrs
Proposed event location and dates: Venue, postcodes and dates must be advised.	Date <b>[REDACTED] June 3-4</b>	Postcode <b>3000</b>
	Venue <b>Melbourne Convention Centre</b>	Suburb/City <b>Melbourne</b>
Events All accredited activities will be advertised on the QI&CPD accredited activities list.	<input type="checkbox"/> by invitation only <input type="checkbox"/> only available to members <input type="checkbox"/> all attendees welcome	
	<input type="checkbox"/> GPs <input type="checkbox"/> GPs & Practice team	

General practice is the first line of management in most cases. The severely unwell, acute patient will by default in most cases be taken directly to an emergency department. There is however a group of patients that will see their General practitioner, prior to becoming unwell. It is imperative that the General Practitioner be well versed in the potential presentations of various conditions, especially cardiac conditions and acute presentations with vague symptoms.

The coreEM Conference covers acute medicine and those patient presentations that may be challenging in General Practice. The most critical acute diseases of acute coronary syndrome, pulmonary embolism, dissection, airways disease and paediatric conditions will provide the general practitioners attending, the most up to date clinical evidence available.

Atypical presentations of potentially lethal conditions such as acute myocardial infarction, pulmonary embolism and dissection can result in misdiagnosis and significant delay in referral for definitive treatment(1) . We know that performance of clinicians in terms of their diagnostic accuracy in acute cardiac related diseases is lower than it should be, resulting in a significant miss rate(2) It is also been shown in the literature that General Practitioners substantially under-treat patients who are at high risk of cardiovascular disease(3)

The main reasons for missed diagnoses is that undifferentiated problems present to General Practice, and pose significant management and investigation and dispositional challenges to the clinician(4)

It is the ability to learn evidence based medicine and to understand that symptoms don't always correlate with clinical conditions and to further develop a patient-safety-related strategy to minimize the chance of a missed diagnosis that is critical(5). Uncertainty in clinical decision making is linked to adverse outcomes in patient care(6).

We know that decision making can be improved by evidence(7) and the formation of appropriate pathways for patients that present with common conditions that may be diagnostic dilemmas, such as syncope and collapse, can result in significant reduction in mortality and morbidity(8) .

The Royal Australian College of General Practice in their Draft statements(9) for inclusion into General Practice Curriculum list procedural skills that are important and a list of minimum Emergency resuscitation Skills. The following list is a major part of this recommendation and will be covered at the coreEM Conference. It includes:

- Early Trauma Management
- Identification of potential neck injury
- ECG Skills
  - Bradycardias
  - atrial tachycardias
  - atrial flutter
- Resuscitation
  - acute asthma
- seizures
- acute myocardial infarction
- emergency treatment of tension pneumothorax
- Within paediatrics
  - recognition and management of the severely ill child.

Bleeker et al. Patient and Doctor Delay in Acute Myocardial Infarction: A Study in Rotterdam, The Netherlands. Br J Gen Prat. 1995;45: 181-184

Chadwick et al Ann of Emergency Medicine 2004;44:565-574  
Heeley et al. Med J Aust 2010 192(5);254-259  
Summerton N. Diagnosis and General Practice. Br J Gen Pract 2000 Dec;50(461);995-1000  
Murtagh J. A Safe Diagnostic Strategy. Murtagh's General Practice. McGraw Hill, Australia, 2007  
Farnan et al. Resident uncertainty in Clinical Decision making and Impact in patient care: A Qualitative Study. Qual Saf Health Care 2008. April;17(2):122-6  
Sackett et al. Clinical Epidemiology. How to do Clinical Practice Lippincott Williams and Williams 2006  
Petkar et al. How to avoid misdiagnosis in patientists presenting with transient loss of consciousness. Postgrad Med J 2006;82:630-641.  
The Royal Australian College of General Practitioners website- Drafts Statements on Curriculum 2010.

#### LEARNING OBJECTIVES

- 1 By the end of this activity participants will be able to have a differential list for the causes of the crying child, including abdominal complains such as intussusception.
- 2 By the end of this activity participants will have an approach to the resuscitation of a patient.
- 3 By the end of this activity participants will have an approach to the management of patients with a hand injury.
- 4 By the end of this activity participants will have an approach to the patient of syncope, including important aspects of history and examination and investigations.
- 5 By the end of this activity participants will have a differential for the various causes of sudden headache and an approach to their investigation.
- 6 By the end of this activity participants will be able to use a protocol based approach, that identifies those conditions that are emergencies in the crying infant and who must be referred to an emergency department.

# Participant evaluation form

Title:

First name:

Surname:

Email:

QA&CPD number:

Address:

## Q1. Please rate to what degree the learning outcomes of the program were met.

Have a list of differentials for the causes of the crying child and know the SIC KID mnemonic

Not met

Partially met

Entirely met

Have an approach to the patient with syncope, including the use of the ECG

Not met

Partially met

Entirely met

Have an approach to the management of the patient with a hand injury

Not met

Partially met

Entirely met

Establish a protocol based approach in managing a patient with sudden onset of headache.

Not met

Partially met

Entirely met

Explain the evidence for resuscitation guidelines and practice/use techniques to improve survival.

Not met

Partially met

Entirely met

## Q2. Rate to what degree your learning needs were met:

Not met

Partially met

Entirely met

## Q3. Rate to what degree this activity is relevant to your practice:

Not relevant

Partially relevant

Entirely relevant

## PRE CONFERENCE QUESTIONNAIRE

1 In terms of vascular access in severe trauma, which is TRUE

- (a) Venous cut-down is the preferred method
- (b) Intraosseous lines should be used when intravenous access will take longer than 60-90 seconds.
- (c) All arrests secondary to trauma need a chest tube insertion into the left thoracic cavity
- (d) A femoral central line should never be used.

2 In adult resuscitation which of the following is TRUE

- a) Airway comes first and is always more important than chest compressions
- b) Depth of compressions is not important, but maintaining a rate of above 120/minute is
- c) Praecordial thump should be used in all unresponsive patients regardless of the rhythm
- d) Our aim is about 100 compressions per minute

3 In terms of syncope, which is TRUE

- a) All patients with syncope need a troponin
- b) The ECG is not essential
- c) Arrhythmia causes of syncope may have a gradual onset of up to 30 seconds
- d) Thoracic aortic dissection does not cause syncope

4 With respect to syncope, which is true?

- (a) The ECG is of no utility
- (b) Long QT syndrome results in systole
- (c) Arrhythmogenic right ventricular dysplasia can result in death
- (d) Brugada Syndrome is treated with a beta blocker

5 In traumatic Cardiac arrest which is true?

- (a) We must treat all patients as a medical cardiac arrest
- (b) Ultrasound plays no role
- (c) Blood products and filling are the most important aspect
- (d) Tranexamic acid works best after 6 hours.

6 Cavernous Venous thrombosis

- (a) May present as a sudden headache
- (b) Does not occur in pregnancy
- (c) Has the distinguishing feature of not having seizures
- (d) Occurs mainly post head injury

7 Low risk BRUE in children has all the following features except

- (a) Age > 60 days
- (b) First episode
- (c) Occurs during sleep
- (d) No CPR performed

8 Blood pressure control in non-traumatic brain bleeds involves

- (a) Maintaining Systolic Blood pressure at approximately 140mmHg
- (b) Maintaining diastolic Pressure above 100mmHg
- (c) Maintaining Systolic Blood pressure at 110 mmHg
- (d) Maintaining blood pressure at its natural level, to perfuse the brain