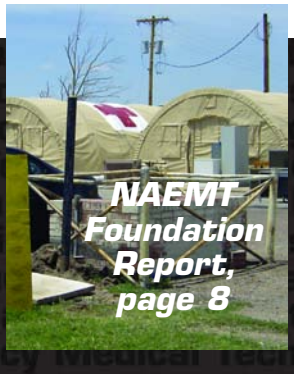
NAEMT news



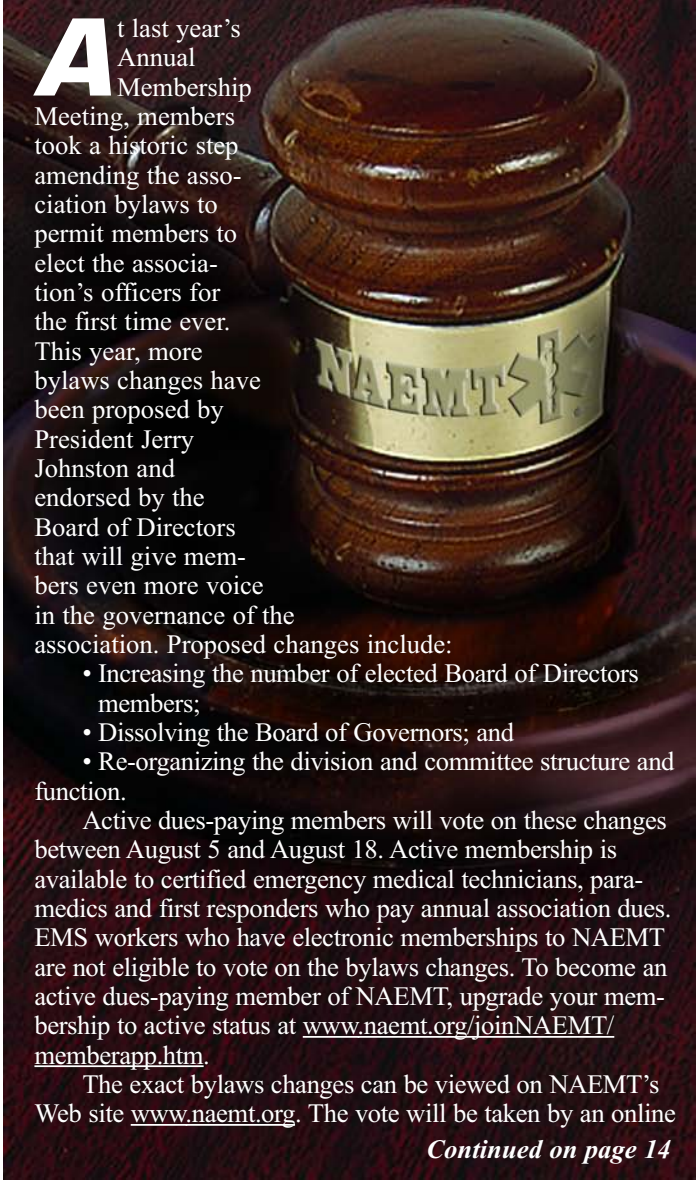
INSIDE:

NAEMT Annual Meeting

Make plans to attend the NAEMT Annual Meeting and EMS EXPO in Orlando. Visit www.emsexpo2007.com to register.

Summer 2007

Bylaws Changes Proposed – Vote Set for August 5-18



At last year's Annual Membership Meeting, members took a historic step amending the association bylaws to permit members to elect the association's officers for the first time ever. This year, more bylaws changes have been proposed by President Jerry Johnston and endorsed by the Board of Directors that will give members even more voice in the governance of the association. Proposed changes include:

- Increasing the number of elected Board of Directors members;
- Dissolving the Board of Governors; and
- Re-organizing the division and committee structure and function.

Active dues-paying members will vote on these changes between August 5 and August 18. Active membership is available to certified emergency medical technicians, paramedics and first responders who pay annual association dues. EMS workers who have electronic memberships to NAEMT are not eligible to vote on the bylaws changes. To become an active dues-paying member of NAEMT, upgrade your membership to active status at www.naemt.org/joinNAEMT/memberapp.htm.

The exact bylaws changes can be viewed on NAEMT's Web site www.naemt.org. The vote will be taken by an online

Continued on page 14

VIEW FROM THE TRENCHES

By Jerry Johnston

Those who know me know I like action. I've never been one to wait around. If there is work to do, I like to roll up my sleeves and get it done and then move on. For the last three years (two years as NAEMT president-elect and almost one year as president), I have been hard at work on a project I believe is vital to the future of this association and vital to the future of EMS in America. That project is giving this association to the membership. It is now time to complete the work.

This issue of *NAEMT News* explains that NAEMT has been taking steps toward giving the membership directly elected representation in the governance of the association. As I travel and speak with

Continued on page 3

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View from the Trenches

Continued from cover

EMTs and paramedics across the country, they want a voice. They want to know that their participation in a national organization means something. They want to know that they have a champion, that someone is listening to them and that they have representation that is responsive and accountable. I believe that we can do nothing less than make this organization open, representative and accountable to the men and women who give so much to their communities every day.

With the endorsement of the Board of Directors, I am proposing that we give each active member of the association the opportunity to elect the representatives of their choice to the Board of Directors.

In expanding the Board of Directors and eliminating the Board of Governors, we are shortening the distance between the active member and the frontline of action in the association.

These 15 representatives will be chosen by you, the members.

Unlike in the past, we will now proudly say that the decisions of NAEMT leaders truly represent the members.

We will have a transparent electoral process, and our future leaders would have more credibility within the EMS community, both locally and nationally, as they represent the needs and interests of NAEMT's members.

Finally, these future directors will be accountable to members. I believe this increased accountability will increase productivity and efficiency, lead to thoughtful decision-making and create proactive leaders who follow through on promises made during their election campaigns.

I am also proposing that we improve our committee and division structure. In the early days of NAEMT, small groups formed under the NAEMT umbrella to address specific issues. I propose we start from scratch and see which divisions are necessary and which ones can be eliminated.

In changing the bylaws to allow the Board of Directors to create and appoint the leadership of these groups, we are lightening our load and giving the association the necessary agility needed in these times of rapid change.

The issues confronting EMS demand that NAEMT assume a lead role in this country now. We need to double our membership, find new avenues for speaking out and attract the best and brightest in this industry.

As I have candidly presented these changes to the Board of Governors, the membership and the entire EMS community, a few people have asked why we need to act this year. They have suggested a slower, more measured approach.

Here is my answer: The members of this association have waited long enough. It is time to entrust them with their association. After all, it is *your* association.

The issues confronting EMS demand that NAEMT assume a lead role in this country now. We need to double our membership, find new avenues for speaking out and attract the best and brightest in this industry. As I write this note, other groups and associations are purporting to speak for EMS. We cannot afford to let this job go undone.

Therefore, I ask that each and every one of you respond when you receive notice to vote for these changes. You can make this vision a reality by taking the time to vote, and by voting "Yes" on the bylaws question. Thank you for helping us to continue our important mission.

NAEMT news

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Submission Guidelines for *NAEMT News*

Articles for *NAEMT News* range in length from 150 words for short news items to 600 words for member profiles. Submit your materials for consideration to jarach1963@aol.com in the text of an e-mail. Photos are welcome, too. Please submit photos in .jpg format that are 300 dpi for the best reproduction quality in the printed newsletter.

NAEMT Donates $1,000 to Support Building of Iowa EMS Memorial

NAEMT donated $1,000 in support of a new EMS memorial, which was dedicated in West Des Moines, Iowa, in honor of Iowa EMS providers who have died in the line of duty or who have made a significant contribution to EMS in the state.

The dedication ceremony on May 19 kicked off EMS Week observances in the Des Moines area. NAEMT President Jerry Johnston and Iowa NAEMT Governor Jeff Dumermuth participated in the dedication ceremony, which was attended by more than 200 people.

The Iowa EMS Memorial features likenesses of a male and female EMS provider holding an EMS Star of Life. Featured on the base of the memorial are the engraved names of Iowa EMS providers who perished in the line of duty. On the opposite side of the memorial are the engraved names of Iowa providers who made significant statewide contributions to the field of EMS. The memorial sculpture is located in a park in West Des Moines.

The Iowa EMS Memorial was dedicated on May 19. The monument will honor EMS workers who have made significant contributions to the profession or who have died in the line of duty.

Hinchey Named NAEMT Medical Director

Paul Hinchey, MD, has been appointed medical director for NAEMT.

"Appointing Dr. Hinchey allows us to further engage the physician community while adding credibility from a clinical perspective," said NAEMT President Jerry Johnston. Hinchey will provide medical direction and overall supervision of the clinical aspects of NAEMT. He will also serve as a resource to the Board of Directors for short- and long-term strategic planning and membership services as they relate to clinical practice.

A former paramedic, Hinchey is the assistant medical director for the Wake County EMS System in North Carolina. He completed his residency and EMS fellowship at the University of North Carolina, Chapel Hill, and is a past recipient of the Jean K. Hollister Memorial Award from the Emergency Medicine Residents' Association.

Hinchey is an attending physician in the department of emergency medicine at WakeMed Health Hospitals in Raleigh and Cary, North Carolina.

Hinchey is a member of the Air Medical Physicians Association, the Medical Society of North Carolina, the American College of Emergency Physicians, the Society of Academic Emergency Medicine and the National Association of EMS Physicians.

NAEMT Issues Position Statement on the Validity of Diverse EMS Delivery Models

In light of a white paper issued by Fire-Based Advocates for EMS in May, NAEMT has issued a position statement on the validity of diverse EMS delivery models.

The fire groups assert that fire-based EMS is the best model for delivering EMS to all communities, but NAEMT supports local decision-making processes with regard to EMS delivery models and believes that no one delivery model is superior to any other.

Read the position statement at www.naemt.org/aboutNAEMT/DiverseEMSDeliveryModels.htm.

NAEMT Foundation Receives Jeffrey Harris Memorial Donation

Samantha Harris, daughter of NAEMT founding member Jeffrey Harris, ran the Boston Marathon in April. She raised $1,540, which she donated to the NAEMT Foundation in her father's memory. Read more about her run at: www.samanthasrun.blogspot.com.

NAEMT Joins IOM Forum Sponsors

NAEMT has signed on as a sponsoring member of the Forum on Medical and Public Health Preparedness for Catastrophic Events, an event organized by the Institute of Medicine. NAEMT will be the only prehospital organization involved in the forum as a sponsoring member.

The Forum will provide an opportunity for stakeholders to sit down together periodically throughout the year and discuss primary issues and policies, make assessments and review outcomes. The forums will focus not only on the immediate responses to disasters and public health crises, but also on the intermediate and long-term needs that arise.

Details of the first forum are still being finalized, but initial attention will be given to the following broad topic areas: medical surge capacity, disaster preparedness training, communication and distribution, psychological and community resilience, and research and evaluation.

In addition to NAEMT, sponsoring members will include federal agencies, state and local

Continued on page 14

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Mid-Year Meeting Brings Board Together

The NAEMT Board of Directors gathered at association headquarters in Clinton, Mississippi, in mid-May. This two-day meeting was the first of its kind for the new headquarters, and it allowed the association board to gather with the entire office staff and see how the new building is working out.

This was the second face-to-face meeting the board has had since last year's Annual Meeting. "Because NAEMT is growing, along with the pace of activity, we simply needed more face-to-face time together to accomplish our goals," said NAEMT President Jerry Johnston.

Membership in the association continues to grow. The association has 31,520 total members, according to the Headquarters Report submitted prior to the meeting. Of those, 25,486 are electronic members. Headquarters staff has processed 8,963 memberships this year, and more than 1,600 complimentary members have converted to a dues-paying membership in the past year.

Along with an in-depth discussion of the proposed bylaws changes (see the related cover story for details), the board also:

Members of the NAEMT Board of Directors met in May for the group's second Mid-Year Meeting of 2007. One of the major topics of discussion was the proposed bylaws change, which members will vote on from August 5 to 18.

- Approved $25,000 annually for scholarships for members to advance their careers. Plans call for four $500 scholarships for first responders, three $5,000 scholarships for EMTs and four $2,000 scholarships for paramedics. This initiative was led by Membership Committee chair Ed Sawicki;
- Approved appointing an association medical director. President Johnston led a search for this position. Paul Hinchey, MD, has been appointed to this position. (See Association Business for more details);
- Approved a search for an executive director for the association. A job description was approved and a plan was made for conducting a search with the goal of filling the position before the Annual Meeting, which is set for October 9 to 13 in Orlando, Florida;
- Approved a position paper that supports the diversity of EMS delivery models. (See Association Business for more details.);
- Voted to support proposed federal legislation that would provide civil liability protection and benefits protection for volunteers responding to disasters; and
- Approved moving forward with a contract with the RedFlash group to better understand the EMS market and promote memberships and educational programs.

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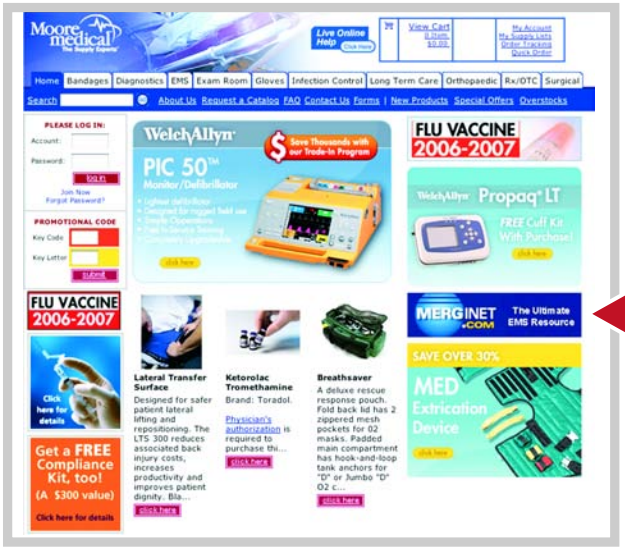

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NAEMT Foundation Provides Money to Tornado Victims

EMS providers in Greensburg, Kansas, have benefited from the generosity of donors to the NAEMT Foundation.

The Foundation gave $500 to each of 10 qualified providers who were affected by the tornado that leveled the town on May 4.

NAEMT Foundation

NAEMT Vice President Connie Meyer and Kansas NAEMT Governor Doug Meyer presented checks to the providers during EMS Week. Kansas Hospital Association President Tom Bell also attended the presentation ceremony.

Receiving checks were Director of Kiowa County EMS Tim Smith, PHTLS and AMLS Faculty Member Jeri Smith, Hospital Administrator Mary Sweet, Aaron Thompson, Bill Odle and Kara Sutton. Four other EMS workers were not present for the ceremony. The Smiths, who are both NAEMT members, coordinated the check presentation.

According to Connie Meyer, Kiowa County EMS was the first county department to resume operations after the storm. The service is currently housed in a travel trailer in the hospital parking lot. It will operate out of a temporary MASH unit, which will be the hospital for the next two years or so, until a new hospital is built.

Soldiers from the Kansas National Guard brought the EMEDS mobile hospital to Greensburg from Topeka on May 12.

"The medical facilities available to the people of Greensburg prior to the tornado are gone," said Maj. Gen. Tod Bunting, the Kansas adjutant general. "The Expeditionary Medical Support System can fill that void because it is a complete self-contained mobile hospital. Just about any medical service people need is available in this hospital and we're happy to give the doctors, nurses and other medical personnel in Greensburg a place where they can resume taking care of the residents."

This temporary MASH unit, set up by members of the Kansas National Guard, will be the Kiowa County Memorial Hospital for the next two years or so, until a new hospital is built.

According to NAEMT Vice President Connie Meyer, Kiowa County EMS was the first county department to resume operations after the storm hit.

The NAEMT Foundation presented checks for $500 each to 10 EMS providers who were affected by the tornados.

The EMS & Rescuer Relief Fund is administered by the NAEMT Foundation, a nonprofit organization under Section 501(c)(3) of the Internal Revenue Code. The Fund was established after 9-11 and disseminated $107,553 to the families of the EMS workers who died responding to the terrorist attacks.

The NAEMT Foundation is seeking donations from individuals, organizations and businesses. It will soon have a Web site to accept online donations. Checks, made payable to the foundation, can be sent to NAEMT Foundation, P.O. Box 1400, Clinton, MS 39060-1400. Donations may be made by phone at (800) 346-2368.

Indications and Usage: DuoDote Auto-Injectors are indicated for the treatment of poisoning by organophosphorus nerve agents as well as organophosphorus insecticides. DuoDote Auto-Injectors should be administered by emergency medical services personnel who have had adequate training in the recognition and treatment of nerve agent or insecticide intoxication.

Important Safety Information: Individuals should not rely solely upon atropine and pralidoxime to provide complete protection from chemical nerve agents and insecticide poisoning. Primary protection against exposure to chemical nerve agents and insecticide poisoning is the wearing of protective garments including masks designed specifically for this use. Evacuation and decontamination procedures should be undertaken as soon as possible. Medical personnel assisting evacuated victims of nerve agent poisoning should avoid contaminating themselves by exposure to the victim's clothing.

In the presence of life-threatening poisoning by organophosphorus nerve agents or insecticides, there are no absolute contraindications to the use of the DuoDote Auto-Injector. When symptoms of poisoning are not severe, DuoDote Auto-Injectors should be used with extreme caution in people with heart disease, arrhythmias, recent myocardial infarction, severe narrow angle glaucoma, pyloric stenosis, prostatic hypertrophy, significant renal insufficiency, chronic pulmonary disease, or hypersensitivity to any component of the product. **PLEASE SEE BRIEF SUMMARY OF FULL PRESCRIBING INFORMATION ON ADJACENT PAGE.**

References: 1. DuoDote™ (atropine and pralidoxime chloride injection) Auto-Injector [package insert]. Columbia, MD: Meridian Medical Technologies™, Inc.; 2007. **2.** Agency for Toxic Substances and Disease Registry. Medical Management Guidelines (MMGs) for nerve agents: tabun (GA); sarin (GB); soman (GD); and VX. Available at: http://www.atsdr.cdc.gov/MHMI/mmg166.html. Accessed February 21, 2007. **3.** Holstege CP, Dobmeier SG. Nerve agent toxicity and treatment. *Curr Treat Options Neurol.* 2005;7:91-98. **4.** Data on file. Columbia, MD: Meridian Medical Technologies™, Inc.

DuoDote™ AUTO-INJECTOR
(atropine and pralidoxime chloride injection)

Rx Only
Atropine 2.1 mg/0.7 mL
Pralidoxime Chloride 600 mg/2 mL

Sterile solutions for intramuscular use only

FOR USE IN NERVE AGENT AND INSECTICIDE POISONING ONLY

THE DUODOTE™ AUTO-INJECTOR SHOULD BE ADMINISTERED BY EMERGENCY MEDICAL SERVICES PERSONNEL WHO HAVE HAD ADEQUATE TRAINING IN THE RECOGNITION AND TREATMENT OF NERVE AGENT OR INSECTICIDE INTOXICATION.

INDICATIONS AND USAGE

DuoDote™ Auto-Injector is indicated for the treatment of poisoning by organophosphorus nerve agents as well as organophosphorus insecticides.

DuoDote™ Auto-Injector should be administered by emergency medical services personnel who have had adequate training in the recognition and treatment of nerve agent or insecticide intoxication.

DuoDote™ Auto-Injector is intended as an initial treatment of the symptoms of organophosphorus insecticide or nerve agent poisonings; definitive medical care should be sought immediately.

DuoDote™ Auto-Injector should be administered as soon as symptoms of organophosphorus poisoning appear (eg, usually tearing, excessive oral secretions, sneezing, muscle fasciculations).

CONTRAINDICATIONS

In the presence of life-threatening poisoning by organophosphorus nerve agents or insecticides, there are no absolute contraindications to the use of DuoDote™ Auto-Injector.

WARNINGS

CAUTION! INDIVIDUALS SHOULD NOT RELY SOLELY UPON ATROPINE AND PRALIDOXIME TO PROVIDE COMPLETE PROTECTION FROM CHEMICAL NERVE AGENTS AND INSECTICIDE POISONING.

PRIMARY PROTECTION AGAINST EXPOSURE TO CHEMICAL NERVE AGENTS AND INSECTICIDE POISONING IS THE WEARING OF PROTECTIVE GARMENTS INCLUDING MASKS DESIGNED SPECIFICALLY FOR THIS USE.

EVACUATION AND DECONTAMINATION PROCEDURES SHOULD BE UNDERTAKEN AS SOON AS POSSIBLE. MEDICAL PERSONNEL ASSISTING EVACUATED VICTIMS OF NERVE AGENT POISONING SHOULD AVOID CONTAMINATING THEMSELVES BY EXPOSURE TO THE VICTIM'S CLOTHING.

When symptoms of poisoning are not severe, DuoDote™ Auto-Injector should be used with extreme caution in people with heart disease, arrhythmias, recent myocardial infarction, severe narrow angle glaucoma, pyloric stenosis, prostatic hypertrophy, significant renal insufficiency, chronic pulmonary disease, or hypersensitivity to any component of the product. Organophosphorus nerve agent poisoning often causes bradycardia but can be associated with a heart rate in the low, high, or normal range. Atropine increases heart rate and alleviates the bradycardia. In patients with a recent myocardial infarction and/or severe coronary artery disease, there is a possibility that atropine-induced tachycardia may cause ischemia, extend or initiate myocardial infarcts, and stimulate ventricular ectopy and fibrillation. In patients without cardiac disease, atropine administration is associated with the rare occurrence of ventricular ectopy or ventricular tachycardia. Conventional systemic doses may precipitate acute glaucoma in susceptible individuals, convert partial pyloric stenosis into complete pyloric obstruction, precipitate urinary retention in individuals with prostatic hypertrophy, or cause inspiration of bronchial secretions and formation of dangerous viscid plugs in individuals with chronic lung disease.

More than 1 dose of DuoDote™ Auto-Injector, to a maximum of 3 doses, may be necessary initially when symptoms are severe. **No more than 3 doses should be administered unless definitive medical care (eg, hospitalization, respiratory support) is available.**

Severe difficulty in breathing after organophosphorus poisoning requires artificial respiration in addition to the use of DuoDote™ Auto-Injector.

A potential hazardous effect of atropine is inhibition of sweating, which in a warm environment or with exercise, can lead to hyperthermia and heat injury.

The elderly and children may be more susceptible to the effects of atropine.

PRECAUTIONS

General: The desperate condition of the organophosphorus-poisoned individual will generally mask such minor signs and symptoms of atropine and pralidoxime treatment as have been noted in normal subjects.

Because pralidoxime is excreted in the urine, a decrease in renal function will result in increased blood levels of the drug.

DuoDote™ Auto-Injector temporarily increases blood pressure, a known effect of pralidoxime. In a study of 24 healthy young adults administered a single dose of atropine and pralidoxime auto-injector intramuscularly (approximately 9 mg/kg pralidoxime chloride), diastolic blood pressure increased from baseline by 11 ± 14 mmHg (mean ± SD), and systolic blood pressure increased by 16 ± 19 mmHg, at 15 minutes post-dose. Blood pressures remained elevated at these approximate levels through 1 hour post-dose, began to decrease at 2 hours post-dose and were near pre-dose baseline at 4 hours post-dose. Intravenous pralidoxime doses of 30-45 mg/kg can produce moderate to marked increases in diastolic and systolic blood pressure.

Laboratory Tests: If organophosphorus poisoning is known or suspected, treatment should be instituted without waiting for confirmation of the diagnosis by laboratory tests. Red blood cell and plasma cholinesterase, and urinary paranitrophenol measurements (in the case of parathion exposure) may be helpful in confirming the diagnosis and following the course of the illness. However, miosis, rhinorrhea, and/or airway symptoms due to nerve agent vapor exposure may occur with normal cholinesterase levels. Also, normal red blood cell and plasma cholinesterase values vary widely by ethnic group, age, and whether the person is pregnant. A reduction in red blood cell cholinesterase concentration to below 50% of normal is strongly suggestive of organophosphorus ester poisoning.

Drug Interactions: When atropine and pralidoxime are used together, pralidoxime may potentiate the effect of atropine. When used in combination, signs of atropinization (flushing, mydriasis, tachycardia, dryness of the mouth and nose) may occur earlier than might be expected when atropine is used alone.

The following precautions should be kept in mind in the treatment of anticholinesterase poisoning, although they do not bear directly on the use of atropine and pralidoxime.

- Barbiturates are potentiated by the anticholinesterases; therefore, barbiturates should be used cautiously in the treatment of convulsions.
- Morphine, theophylline, aminophylline, succinylcholine, reserpine, and phenothiazine-type tranquilizers should be avoided in treating personnel with organophosphorus poisoning.
- Succinylcholine and mivacurium are metabolized by cholinesterases. Since pralidoxime reactivates cholinesterases, use of pralidoxime in organophosphorus poisoning may accelerate reversal of the neuromuscular blocking effects of succinylcholine and mivacurium.

Drug-drug interaction potential involving cytochrome P450 isozymes has not been studied.

Carcinogenesis, Mutagenesis, Impairment of Fertility: DuoDote™ Auto-Injector is indicated for short-term emergency use only, and no adequate studies regarding the potential of atropine or pralidoxime chloride for carcinogenesis or mutagenesis have been conducted.

Impairment of Fertility: In studies in which male rats were orally administered atropine (62.5 to 125 mg/kg) for one week prior to mating and throughout a 5-day mating period with untreated females, a dose-related decrease in fertility was observed. A no-effect dose for male reproductive toxicity was not established. The low-effect dose was 290 times (on a mg/m^2 basis) the dose of atropine in a single application of DuoDote™ Auto-Injector (2.1 mg).

Fertility studies of atropine in females or of pralidoxime in males or females have not been conducted.

Pregnancy:

Pregnancy Category C: Adequate animal reproduction studies have not been conducted with atropine, pralidoxime, or the combination. It is not known whether pralidoxime or atropine can cause fetal harm when administered to a pregnant woman or if they can affect reproductive capacity. Atropine readily crosses the placental barrier and enters the fetal circulation.

DuoDote™ Auto-Injector should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Atropine has been reported to be excreted in human milk. It is not known whether pralidoxime is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when DuoDote™ Auto-Injector is administered to a nursing woman.

Pediatric Use: Safety and effectiveness of DuoDote™ Auto-Injector in pediatric patients have not been established.

ADVERSE REACTIONS

Muscle tightness and sometimes pain may occur at the injection site.

Atropine

The most common side effects of atropine can be attributed to its antimuscarinic action. These include dryness of the mouth, blurred vision, dry eyes, photophobia, confusion, headache, dizziness, tachycardia, palpitations, flushing, urinary hesitancy or retention, constipation, abdominal pain, abdominal distention, nausea and vomiting, loss of libido, and impotence. Anhidrosis may produce heat intolerance and impairment of temperature regulation in a hot environment. Dysphagia, paralytic ileus, and acute angle closure glaucoma, maculopapular rash, petechial rash, and scarletiniform rash have also been reported.

Larger or toxic doses may produce such central effects as restlessness, tremor, fatigue, locomotor difficulties, delirium followed by hallucinations, depression, and, ultimately medullary paralysis and death. Large doses can also lead to circulatory collapse. In such cases, blood pressure declines and death due to respiratory failure may ensue following paralysis and coma.

Cardiovascular adverse events reported in the literature for atropine include, but are not limited to, sinus tachycardia, palpitations, premature ventricular contractions, atrial flutter, atrial fibrillation, ventricular flutter, ventricular fibrillation, cardiac syncope, asystole, and myocardial infarction. (See **PRECAUTIONS**.)

Hypersensitivity reactions will occasionally occur, are usually seen as skin rashes, and may progress to exfoliation. Anaphylactic reaction and laryngospasm are rare.

Pralidoxime Chloride

Pralidoxime can cause blurred vision, diplopia and impaired accommodation, dizziness, headache, drowsiness, nausea, tachycardia, increased systolic and diastolic blood pressure, muscular weakness, dry mouth, emesis, rash, dry skin, hyperventilation, decreased renal function, and decreased sweating when given parenterally to normal volunteers who have not been exposed to anticholinesterase poisons.

In several cases of organophosphorus poisoning, excitement and manic behavior have occurred immediately following recovery of consciousness, in either the presence or absence of pralidoxime administration. However, similar behavior has not been reported in subjects given pralidoxime in the absence of organophosphorus poisoning.

Elevations in SGOT and/or SGPT enzyme levels were observed in 1 of 6 normal volunteers given 1200 mg of pralidoxime intramuscularly, and in 4 of 6 volunteers given 1800 mg intramuscularly. Levels returned to normal in about 2 weeks. Transient elevations in creatine kinase were observed in all normal volunteers given the drug.

Atropine and Pralidoxime Chloride

When atropine and pralidoxime are used together, the signs of atropinization may occur earlier than might be expected when atropine is used alone.

OVERDOSAGE

Symptoms:

Atropine

Manifestations of atropine overdose are dose-related and include flushing, dry skin and mucous membranes, tachycardia, widely dilated pupils that are poorly responsive to light, blurred vision, and fever (which can sometimes be dangerously elevated). Locomotor difficulties, disorientation, hallucinations, delirium, confusion, agitation, coma, and central depression can occur and may last 48 hours or longer. In instances of severe atropine intoxication, respiratory depression, coma, circulatory collapse, and death may occur.

The fatal dose of atropine is unknown. In the treatment of organophosphorus poisoning, doses as high as 1000 mg have been given. The few deaths in adults reported in the literature were generally seen using typical clinical doses of atropine often in the setting of bradycardia associated with an acute myocardial infarction, or with larger doses, due to overheating in a setting of vigorous physical activity in a hot environment.

Pralidoxime

It may be difficult to differentiate some of the side effects due to pralidoxime from those due to organophosphorus poisoning. Symptoms of pralidoxime overdose may include: dizziness, blurred vision, diplopia, headache, impaired accommodation, nausea, and slight tachycardia. Transient hypertension due to pralidoxime may last several hours.

Treatment: For atropine overdose, supportive treatment should be administered. If respiration is depressed, artificial respiration with oxygen is necessary. Ice bags, a hypothermia blanket, or other methods of cooling may be required to reduce atropine-induced fever, especially in children. Catheterization may be necessary if urinary retention occurs. Since atropine elimination takes place through the kidney, urinary output must be maintained and increased if possible; intravenous fluids may be indicated. Because of atropine-induced photophobia, the room should be darkened.

A short-acting barbiturate or diazepam may be needed to control marked excitement and convulsions. However, large doses for sedation should be avoided because central depressant action may coincide with the depression occurring late in severe atropine poisoning. Central stimulants are not recommended.

Physostigmine, given as an atropine antidote by slow intravenous injection of 1 to 4 mg (0.5 to 1.0 mg in children) rapidly abolishes delirium and coma caused by large doses of atropine. Since physostigmine has a short duration of action, the patient may again lapse into coma after 1 or 2 hours, and require repeated doses. Neostigmine, pilocarpine, and methacholine are of little benefit, since they do not penetrate the blood-brain barrier.

Pralidoxime-induced hypertension has been treated by administering phentolamine 5 mg intravenously, repeated if necessary due to phentolamine's short duration of action. In the absence of substantial clinical data regarding use of phentolamine to treat pralidoxime-induced hypertension, consider slow infusion to avoid precipitous corrections in blood pressure.

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Live from Clinton! It's NAEMT!

Clinton, Mississippi, is more than 1,600 miles from Hollywood, but that hasn't stopped NAEMT from using video and television to promote EMS to the American public. In January, NAEMT released a 30-second Public Service Announcement (PSA) stressing the ways that people can recognize and support EMS. As of May 1, that PSA had aired nearly 300 times on 18 TV stations in 16 markets. An estimated 4.8 million people have seen the video.

In May, NAEMT, in conjunction with the National Athletic Trainers Association, released a second 30-second PSA, which is intended to raise the public's awareness of dehydration and heat illness during the warm weather. This PSA is a re-make of a similar video that was released last summer and aired 600 times with a viewership of 14 million people nationwide. The 2007 version features NAEMT member Gary Althaus of Waco, Texas, who was selected as the NAEMT spokesman after a call for audition tapes from NAEMT members.

The New Face of NAEMT

Althaus is featured in this summer's new public service announcement about the dangers of dehydration and heat-related illness. Soccer star Mia Hamm and Mike Carroll of the National Athletic Trainers Association also appear in the 30-second spot, which is slated to air nationally and is likely to be seen by millions of viewers.

This summer is the second year in a row that NAEMT was selected to participate in the hot weather campaign sponsored by Gatorade.

Althaus was selected as NAEMT's spokesman for this summer's PSA based on his experience and the submission of a video clip and resume.

A paramedic who holds a bachelor of science degree from the University of Iowa, Althaus works as an educator and executive territory manager for Laerdal Medical.

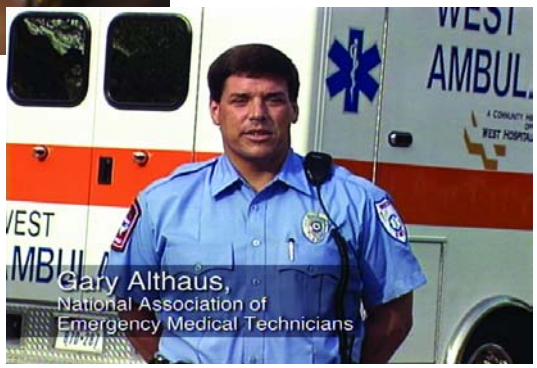
Althaus' career at Laerdal began in 1999, where he worked as an account executive for the Latin America territory. In 2000, he served as the Medical Education Facilitator for the western region of the United States. In 2007, he became the Executive Territory Manager for Central and South Texas.

He is a Texas EMS State Instructor and Examiner and is a certified instructor for the following courses: Basic Life Support, Advanced Cardiac Life Support, Pediatric Advanced Life Support and START Triage. Certified as a Critical Incident Stress Management Facilitator (CISM), he has audited several nursing and physician emergency courses and earned his registered nurse degree this year.

His on-camera credits include Laerdal's instructional DVD for the MegaCode Kelly VitalSim manikin. Althaus volunteers his time on the ambulance with West EMS in West, Texas.

NAEMT received many outstanding applications for the job of NAEMT spokesperson and will maintain an ongoing list of these individuals to participate in public relations activities on an as-needed basis.

These NAEMT member/spokespersons are: Karine Aebi, Caldwell, Idaho; Scott Barthelmass, St. Louis, Missouri; Shane Fabie, Lompoc, California; Jennifer Foreman, Orondo, Washington; Daniel Glick, Ballston Spa, New York; Susanna Henry, Oakland, New Jersey; Lisa Valadie, Madison, Mississippi; Deborah Whitcraft, Beach Haven, New Jersey.



Videos Benefit Everyone

"NAEMT is in good shape financially, so we have the wherewithal to fund these kind of projects to promote EMS," said NAEMT President Jerry Johnston. "This is a win-win effort because it raises the profile of the association and also educates the public. In that way, these videos benefit everyone in EMS."

Both PSAs can be viewed on the NAEMT Web site at www.NAEMT.org.

Because of the success of NAEMT's PSAs, the Board has approved a plan to develop another video this year that addresses the issue of EMS recruitment. This video is in the planning stage, and will likely be 10 to 15 minutes long. It will be available on the NAEMT Web site, will be promoted to television stations, and will be offered to NAEMT members for use in their communities.

PHTLS

The PHTLS Executive Council (EC) met in Atlanta for a midyear meeting in May. The EC was delighted to have Norman E. McSwain, Jr., MD, attend after his [too long] absence due to illness. Also returning after a sojourn is Steve Mercer, who agreed to resume work with the EC as Education Coordinator - welcome back!

The EC would like to take this opportunity to thank Nita Ham and Melissa Alexander for their contributions to PHTLS as part of the EC, and especially for all of the work they accomplished for the 6th edition course.

Included within the meeting agenda was the assignment of various important roles for PHTLS. We have a new Regional Coordinator appointed for Region 1. Mike Hunter of Massachusetts has agreed to take on the role. Puerto Rico has a new Coordinator and Medical Director, Juan Calderon and Dr. Q. Manuel Canario, respectively. And the following report from Region 3:

"PHTLS Region 3 saw a change in state coordinator for both Arizona and Idaho. Kathy Stelfox, the Arizona state coordinator, served since 2003 and provided assistance to her PHTLS instructors assuring their success and the continued development of PHTLS in Arizona. She assisted in the transition of Chris Burrows into the new SC position.

Idaho state coordinator Stephanie Hillius also served her state since 2003, providing Idaho with a conscientious approach to continued growth and implementation of PHTLS. She is being succeeded by Jeff Bates as the new state coordinator and is assisting in the transition.

We wish both state coordinators leaving their positions the very best of luck and welcome the new state coordinators to their position assuring the continuation of progress in their states. Both new SCs have a very active past history with PHTLS both as instructors and coordinators." - *Craig Jacobus, Region 3 Coordinator*

Jeffrey Salomone, MD, Deb Kitchens, RN, EMT-P, and Ken Cardona, MD, traveled to Puerto Rico in March to train new instructors, update current instructors and re-establish PHTLS Faculty in Puerto Rico.

In Canada, Sally Downes has been appointed as the Coordinator for Manitoba. Contact information for all of these individuals is available on the Web site.

Preparations are being made to build new International program sites in Poland, scheduled for July; Lithuania in November; Germany in September and Costa Rica before the end of the year. These courses are being facilitated by both EC and International Faculty who have agreed to lend their expertise as part of the team.

The EC is continuing its work to refine the PHTLS program by soliciting feedback from Faculty and course participants. Please participate in this process and let us know how the program and materials are working for you; notices will be posted on the listservs periodically asking for your comments, ideas, etc.

Additional materials are being developed to enhance the basic PHTLS program as well; these will include online mini-courses, additional teaching tools and podcasts. Podcasting, in particular, is quickly becoming a popular method of delivering information and education to a wide audience, and at low cost to both producer and user.

The PHTLS EC members see podcasting as a unique opportunity to share the philosophies and science behind PHTLS. Podcasts first became available for download in June at www.PHTLSpodcast.com and www.apple.com/itunes.

Additional materials are being developed to enhance the basic PHTLS program as well. Mini-courses and podcasts will soon be offered on the PHTLS Web site.

The NAEMT Annual Meeting and EMS EXPO will take place in Orlando from October 9 to 13, 2007. PHTLS will host the following events:

- October 10, 8 am to 5 pm: PHTLS Instructor/ Transition Course
- October 11, 9 am to 1 pm: PHTLS Annual Meeting
- October 11, 3 pm: Scott Frame Memorial Lecture. This year's Scott Frame Lecture is titled "The History of PHTLS in Latin America," presented by Dr. Osvaldo Rois

Please join us at these events, and utilize these forums to let us know how to serve you better.

-Mary-Ann Clarkes

AMLS

AMLS has had several requests for continuing education (CE) approval for nurses. An application has been completed to the Air and Surface Transport Nurses Association (ASTNA) for approval of nursing CEs.

In order to facilitate the application for nursing continuing education requests, the individual AMLS course coordinators may contact Ann Bellows at Southwest MedEvac (a.bellows@southwestmedevac.com) for the process.

At this time, Southwest MedEvac has obtained continuing education approval for nurses. Ann has the application Southwest Med Evac used to obtain the approval.

Until approval by ASTNA has been received, please contact Ann and she will be happy to share the materials she has completed.

Look for several AMLS offerings at the NAEMT Annual Meeting in Orlando. Preconference workshops include a two-day AMLS Provider Course on October 9 and 10 and an AMLS Instructor Course set for the evening of October 10. The AMLS Annual Meeting is set for 1:30 pm on October 11, and it is open to anyone with an interest in AMLS.

Visit www.naemt.org/AMLS/resourceLibrary/Expo2007.htm for more information about AMLS activities in Orlando.

Educational Program Events During NAEMT Annual Meeting

October 9: EPC Annual Meeting
October 9 and 10: AMLS Provider Course
October 9 and 10: EPC Provider Course
October 10: PHTLS Instructor/Transition Course
October 10: AMLS Instructor Course
October 10: EPC Instructor Course
October 11: AMLS Annual Meeting
October 11: PHTLS Annual Meeting
October 11: Scott Frame Memorial Lecture

EPC

The Emergency Pediatric Care Program Executive Council (EC) met for its Mid-Year Meeting in May.

One of the significant projects the EC worked on during its meeting was the revision of the current slide set. Assignments were made to EC members to complete the slide sets, which are scheduled to be completed by mid-June. Revisions to the 10 EPC PowerPoint presentations were also discussed during the meeting.

The EC forwarded a proposal to the NAEMT Board of Directors for final approval to have CentreLearn.com prepare a Web-based educational course.

Plans are underway for the EPC Annual Meeting and preconference workshops, which will take place before the NAEMT Annual Meeting in Orlando in October. The EPC Annual Meeting is scheduled for 6 pm October 9 in Orlando. The two-day EPC Provider Course is scheduled for October 9 and 10, and the EPC Instructor Course will take place in the evening of October 10.

More information about EPC events in Orlando is available online at www.naemt.org/EPC/resourceLibrary/Expo2007.htm.

Bylaws Changes

Continued from cover

ballot. In an effort to promote fairness and transparency, NAEMT has contracted with an outside company to conduct and validate the Internet-based vote. Paper ballots will be made available to those who request them.

Proposed Changes

NAEMT was founded in 1975 as a consortium of state EMS associations. Representatives from these associations formed the nucleus of the first Board of Governors, which has made most of the association's decisions, including the selection of the Board of Directors.

Last year, a bylaws change allowed members to begin voting directly for the association officers. In accordance with last year's change, the next Board of Directors will be chosen in part by the Governors and in part by the members. In the future, the Board will consist of five executive positions (the association officers) and 10 directors. The position of vice president has been eliminated because the position of president-elect has been added.

NAEMT President Jerry Johnston does not believe last year's changes went far enough. "It is time to give NAEMT back to its members completely."

The proposed bylaws change would increase the size of the Board of Directors to 15 members, up from its current 11. Directors would be elected regionally by NAEMT members.

The other major bylaws change has to do with the structure of the association's divisions and committees. Under the current system, division leaders are elected by the division members who attend the Annual Meeting, rather than a general vote of the division membership.

"Let's look at the organization and figure out what we need and what we don't need," Johnston said. "Then let's select leaders with proven track records who are accountable to their membership and who will provide value-added service to the organization."

Arguments For and Against

Johnston sees several important benefits to a larger Board of Directors, including:

- Real accountable regional representation for NAEMT members;
- Additional opportunities for those who wish to pursue leadership positions;
- Increased productivity of the leadership;
- A better cross-section and representation to the membership;
- Improved organizational efficiency;
- Transparency to the organization and our membership; and
- An opportunity for the current governors to run for a seat on the larger Board of Directors.

These changes are part of an overall effort by association leaders to improve its image and increase NAEMT's membership. "It's difficult to encourage people to spend hard earned money to join an association in which they do not have direct representation," said Johnston.

Not everyone agrees with Johnston, and some NAEMT leaders have voiced their opposition to the proposed changes. Among their concerns are the fact that NAEMT made a change to its bylaws last year that has not yet even been implemented. These people have said that the organization might be better served by taking a more cautious approach to change.

In addition, the proposed bylaws change could cause current NAEMT leaders to lose their positions because a new albeit larger Board of Directors would not have enough open seats to accommodate all of the existing governors. Some NAEMT divisions could disappear if the bylaws are changed.

While acknowledging these views, Johnston and the majority of the Board of Directors feel that moving forward is important. "I've spoken to members and believe they are embracing these changes," said Johnston. "We look forward to continuing our movement toward transparency and more sound organizational structure and business practice." ✱

Association Business

Continued from 14

associations, health professional associations, and private sector business associations.

Membership Committee, Industrial Division Leadership Changes

A reassignment and a resignation have resulted in new chairs for the NAEMT Membership and Credentials Committee and the Industrial Division.

Bubba Bell has been reassigned from the Membership and Credentials Committee to be NAEMT's contact with the House Homeland Security Committee because his home representatives have leadership roles in the committee. This change will help NAEMT in facilitating dialogue with this extremely important group, according to NAEMT President Jerry Johnston.

NAEMT Treasurer Ed Sawicki has been named as the new chair of the Membership and Credentials Committee.

Dennis Wilham has resigned as chair of the Industrial Division. He has been replaced by former vice chair Les Powell.

NAEMT Supports Pediatric Grant

NAEMT is supporting a targeted issues grant submitted to EMSC by Children's National Medical Center in Washington, DC.

The grant submission is titled "Development of a Pediatric Off-Line Medical Direction Tool Kit." Kathleen Brown, MD, will serve as principal investigator. ✱

NAEMT participated in the Rural Domestic Preparedness Consortium (RDPC), which took place in May at Findlay College in Ohio. Willie Johnson (left) of the Department of Homeland Security, provided consortium participants with an update on the DHS/FEMA National Training Program. Participants also received updates on curricula under development at five colleges and universities and a progress report from Linda Mayberry, RDPC executive director (center). Craig Jacobus (right) represented NAEMT.

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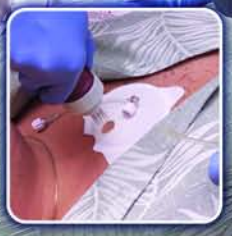

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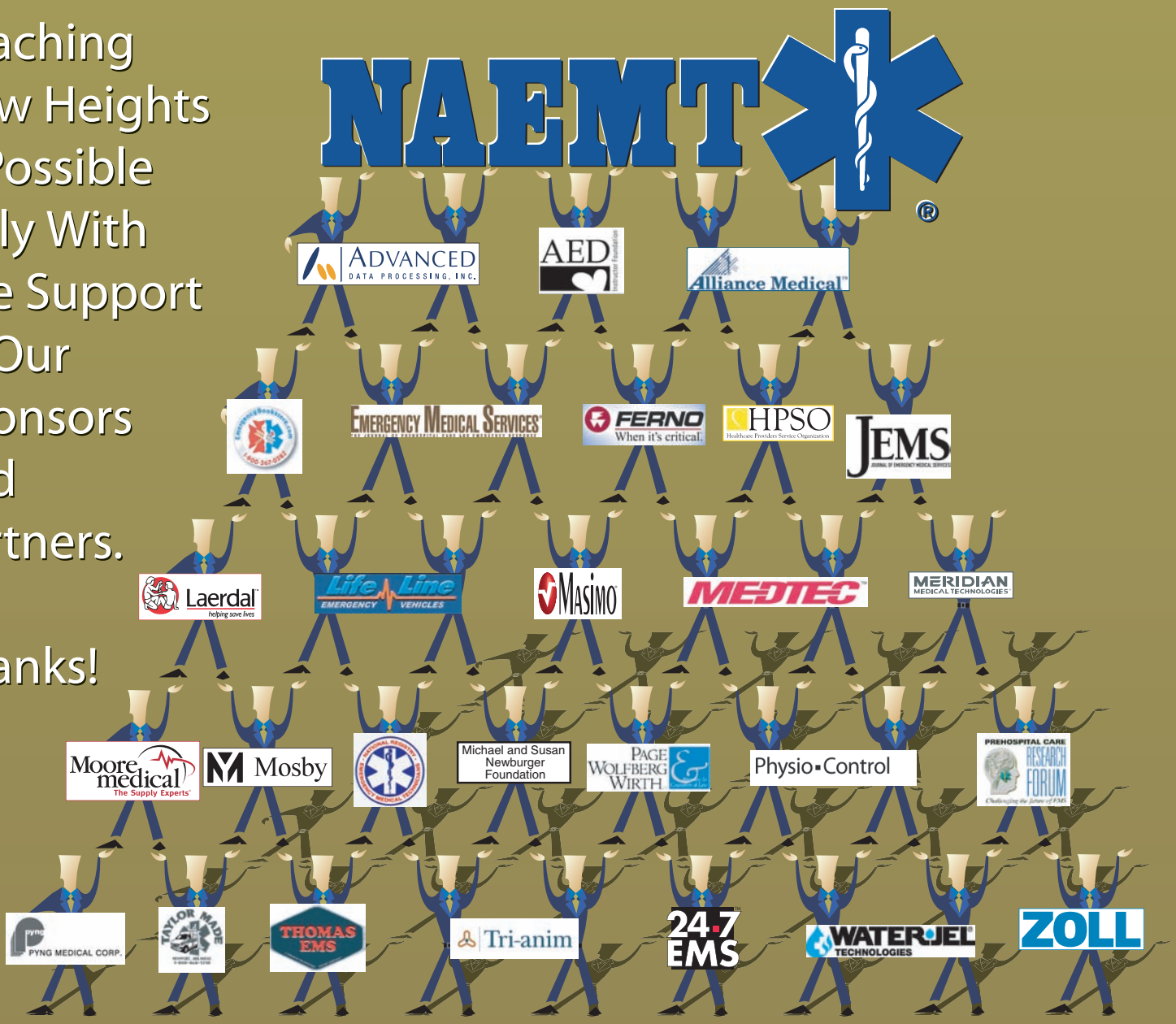

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