

Rap #26, HEENT

[Trick of the Trade: Extra-Oral Reduction Technique for Anterior Mandible Dislocation](#), (ALIEM, 1/26/2016). Reviewed by Kevin Torkelson

1. Place the patient in either sitting or supine position.
2. The provider should stand in front of the patient.
3. The provider places their thumb on the patient's cheek, on the mandibular ramus and coronoid process of the dislocated mandible, and applies persistent pressure posteriorly (figure 3).
4. The fingers are placed behind the angle of the mandible to stabilize the grip.
5. At the same time on the opposite side, the provider places their fingers from the other hand on the angle of the mandible and pulls, applying anterior force (figure 4). Note that this maneuver causes further anterior dislocation of the ipsilateral TMJ, rotates the jaw, and facilitates contralateral TMJ reduction.

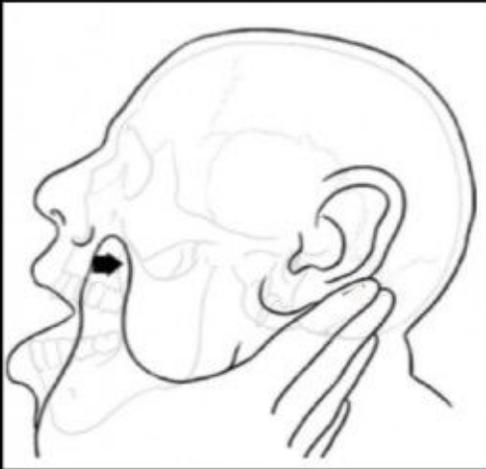


Figure 3

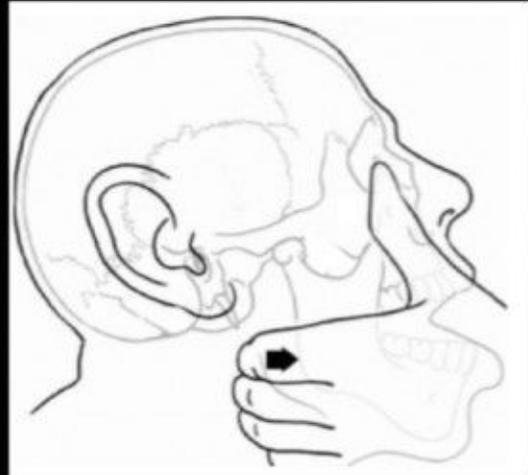


Figure 4

Score

| Tier 1: BEEM Rater Scale | Score-choose only 1 | Tier 2: Content accuracy | Score-choose only 1 | Tier 3: Educational Utility | Score-choose only 1 | Tier 4: EBM | Score-choose only 1 | Tier 5: Referenced | Score-choose only 1 |
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| Your Score | 4 | | 7 | | 2 | | 1 | | 2 |

[Procedural Blog EXTRA: Reduction of TMJ Dislocation](#) (Brown EM Residency Blog, 11/26/2015). Reviewed by Allie Knorzer

Reduction of TMJ Dislocation

Mechanism: mandibular condyle moves anteriorly and becomes locked > spasms of muscles and trismus

Preparation: sedation? Local anesthesia?

Reduction Techniques: gag reflex, syringe, intraoral (rock mandible and have patient open mouth wider)

Post-reduction: gauze around face

Discharge Instructions: minimize jaw opening, soft diet, NSAIDS, muscle relaxants, ENT/oral surgery referral

Score:

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[The Emergency Department Management of Posterior Epistaxis](#) (EMDocs.net, 10/6/1016). Reviewed by Zlata Vloder

Epidemiology:

- 10% of bleeds are posterior
- Bimodal age distribution: 2-10 years & 50-80 years
- Winter months

Etiologies:

Local Causes

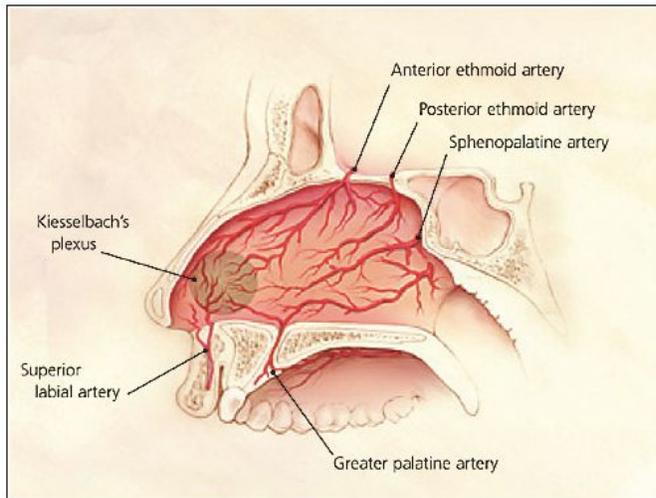
Chronic sinusitis
 Epistaxis digitorum (nose picking)
 Foreign bodies
 anticoags, NSAIDs)
 Intranasal neoplasm/polyp
 uremia)
 Irritants (e.g., cigarette smoke)
 Medications (e.g., topical steroids)
 Rhinitis
 Septal deviation/perforation
 Trauma
 Vascular malformations/telangiectasias

Systemic Causes

Hemophilia
 Leukemia
 Medications (e.g., aspirin,
 Platelet dysfunction (cirrhosis,
 Thrombocytopenia

Brief Anatomy:

- sphenopalatine artery and terminal branches of the maxillary artery

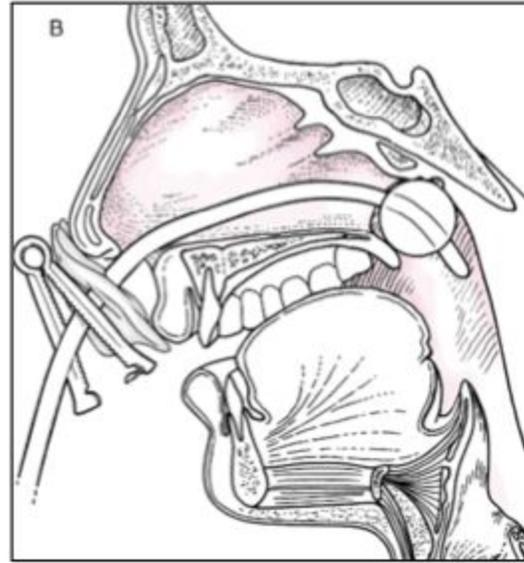
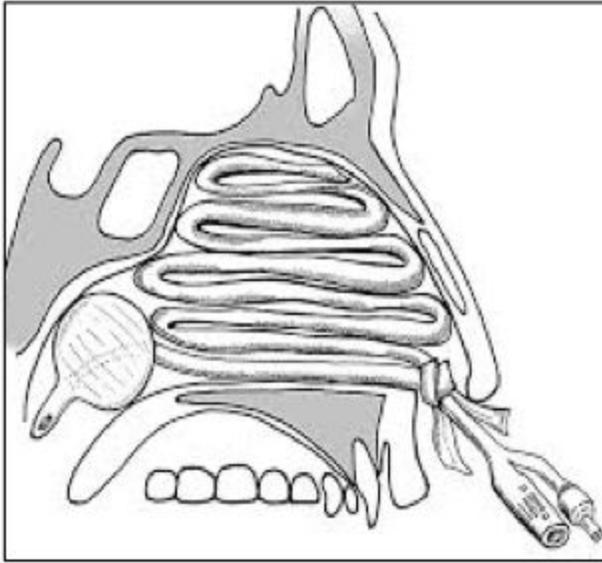


Evaluation:

- ABCs
- If time, find out: onset and activity at this time, frequency, ROS (rashes), PMH (cirrhosis, cancer, etc.), Surg hx, Med review (coags), Family hx
- When to think it's posterior: adult, nausea, hematemesis, hemoptysis, bilateral nares, oropharynx covered in blood, persistent bleeding after packing
- Labs? If unstable or potential to be unstable

Management:

- Foley



- Packing – rare in ED

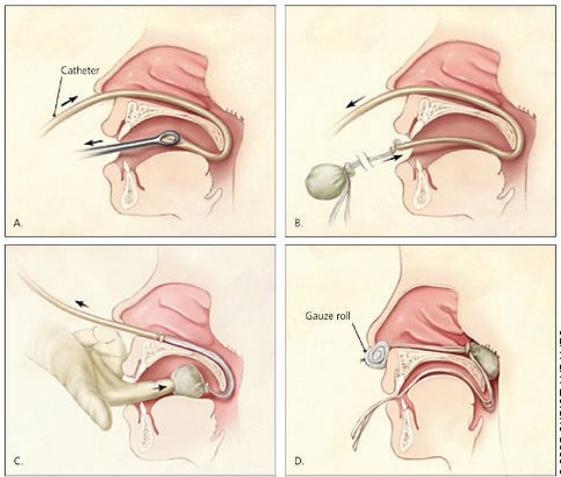


Figure 8 – Application of Posterior Nasal Packing. A. After anesthesia is obt

- Other devices

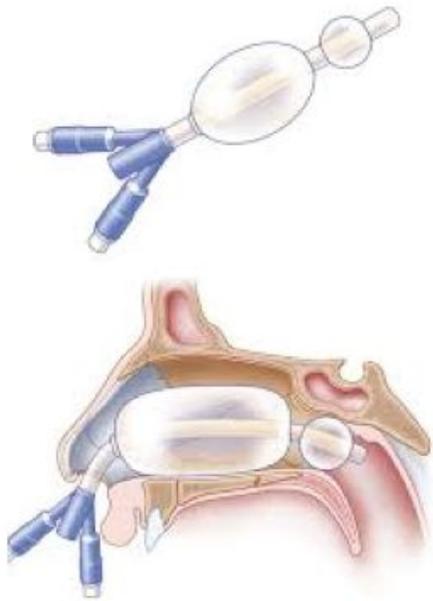


Figure 7 - Storz T3100¹⁷

Complications:

- patient discomfort, otitis media, sinus obstruction, pressure necrosis of the nasal mucosa and cartilage, pressure necrosis of the nasal ala (if packing secured inappropriately), hypoventilation, and toxic shock syndrome

Disposition:

- First Line: PO cephalexin 250–500 mg QID or PO amoxicillin/clavulanate 250–500 mg TID
- Second line: PO clindamycin 150–300 mg QID or PO trimethoprim/sulfamethoxazole DS
- Posterior: Admit (hypoxia, dysrhythmias)

FYI: Epistaxis associated with htn. Unclear why. To treat htn, should treat the epistaxis.

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[TranSESophageal Echo](http://5minsono.com) (5minsono.com) reviewed by Aaron Gronseth

- In ED, ideal for continuous monitoring during resuscitation.
- Low risk of esophageal injury (0.03%).
- 4 basic views, fairly equivalent to the four transthoracic views.
 - Mid-esophageal 4 chamber – behind left atrium.
 - Mid-esophageal long axis – Flex 120 degrees to see aortic valve in same plane.
 - Bicaval- Turn probe right to see IVC/SVC.
 - Trans-gastric short axis – Advance into stomach, anteflex.
- Much better to just watch the video.
- Score:

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[2017 Literature Review](#) (Foamcast.com, 3/21/2018). Reviewed by Brian Mehus

Steroids in Urticaria

- RCT comparing [steroid + antihistamine] vs [placebo + antihistamine]
- conclusion - unlikely to be benefit from addition of steroids to antihistamines in acute urticaria though study not powered to detect small difference

Steroids in Pharyngitis

- meta-analysis examining addition of steroids to standard of care (analgesia, possible antibiotics) or placebo in pharyngitis
- conclusion - dose of steroids may result in quicker resolution of symptoms, though studies examined had some heterogeneity in methods

Bolus IV Nitro for Acute Heart Failure

- chart review looking at administration of IV nitro in ED for acute heart failure
- conclusion - bolus dose IV nitro may mitigate need for infusion. Alternatively, starting infusion at 300-400 mcg/min for a few minutes may provide adequate bolus and gtt may be more easily titrated according to patient needs

Post Contrast AKI (CIN)

- examined rate of AKI in patients undergoing [CT w/ contrast] vs [CT noncon, or no CT]
- conclusion - no evidence that IV contrast is independent risk factor for development of AKI in patients with GFR >30

CT Scan for Globe Rupture

- retrospective cohort study examining diagnostic accuracy of CT orbits for globe rupture
- conclusion - do not rely on negative CT to rule out ruptured globe, sensitivity 51-77%. Consult ophthalmology if clinical suspicion is high.

Asymptomatic C spine Fractures in Older Patients

- retrospective cohort study looking at older patients (≥ 55) with C spine fractures, association between exam and CT findings
- conclusion - older patients can present with asymptomatic C spine fractures but results did suffer from some bias.

Ultrasound and Cardiac Arrest

- 2 studies examining ultrasound in cardiac arrest
- US increases length of pulse checks (17 seconds vs 11 seconds)
- only moderate interrater agreement between clinicians with interpretation of ultrasound clips, most disagreement with interpreting cardiac standstill.

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