Hiding in Plain Sight: Human Trafficking and the Emergency Department

By Hanni Stokloas MD
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A teenaged girl is lured from the Medfield library by a man she met online and forced into sex slavery. Two women are offered drugs outside of medical facilities in the Boston area and subsequently locked away in Roxbury, forced to sell their bodies. East Asian women are brought through South Station and shuttled to wealthy suburbs to work in “massage parlors.” Vietnamese women, promised a better life in the United States, are forced to work in nail salons by day, and engage in sex work at night.

What do all of these stories have in common? They are from Massachusetts news stories depicting sex trafficking.

Continued on Page 4
Making sense of the Massachusetts Prescription Drug Monitoring Program

By Chris Griggs MD
Boston Medical Center

A patient presents to your ED complaining of severe sciatica. The patient has allergies to NSAIDs and reports acetaminophen does not work. You consult the Massachusetts prescription drug monitoring program (PDMP) before prescribing an opioid. The patient has 15 prescriptions over the past year from 8 different providers. Are you concerned about this patient?

In response to the growing epidemic of prescription drug abuse, last year the MA legislature passed a law mandating the use of the PDMP for all prescriptions of schedule II and III medications to new patients.

This mandate was passed despite scant data demonstrating the effectiveness of the PDMP in curbing abuse or overdose of prescriptions.

The PDMP reports are generated from data sent from MA pharmacies. The pharmacy reports each schedule II through V prescription filled, name of the patient, dosage, amount of pills, prescriber information, and method of payment. This data must be reported to the state within 7 days of the prescription but usually appears in the database two to three weeks from when the prescription is filled.

Prescriber information is based on DEA numbers and reports a registered work address. In the case of residents, hospital-based DEA numbers are used and the name of the hospital and its address are reported. Prescriptions filled in pharmacies of neighboring states are not reported as there is not interstate data sharing agreement at this time. The MA DPH reports there may be flaws in the data from name misspelling, use of nicknames, use of false identities, and errors in data entry at the hospital, clinic, or pharmacy.

With the above limitations in mind, the previous patient profile becomes more complex in its interpretation. Some red flags may be overlapping prescriptions from two different providers in a short period of time. While overlapping prescriptions are a clear red flag for concern, most patient profiles are more difficult to interpret. For example, it is difficult to tell if the 8 different providers in the above example are working in conjunction with each other through the same clinic/hospital system. The best course of action in these cases would be to take the PDMP report to the patient, expressing your concern and having a discussion with the patient regarding their report.

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Treading water:
Why Emergency Departments cannot be a Primary Care Provider

By Fraser Mackay MD and Joel Miller MD
BayState Medical Center

Even though my shift was ending, a nurse insistently asked me to see Ms. Smith. She had been waiting in a room for twenty minutes, unmonitored, and with only “weakness” listed as her chief complaint. Somnolent and pale, she barely reacted to the blood pressure cuff inflating; the monitor finally settled on a systolic pressure of 70 mm Hg. By the time the fluids were hung and the labs sent, thirty four minutes had passed since the patient first entered the ED. As I prepared the team for intubation, the day’s census swam through my head: chronic back pain, rashes, URIs. Just prior to seeing Ms. Smith I had spent twenty minutes addressing another patient’s outrage as to why I would not refill her Valium and Percocet prescriptions.

Variety in patient conditions and acuity typifies the clinical experience of Emergency Physicians (EPs). Often, it is one of the reasons why we went into this profession. However, increases in ED crowding have begun to present significant delays to patient care and safety. We are finding that crowding delays resuscitative efforts for patients in critical condition, increasing ED and admitted patient mortality. Multiple studies have established this nationwide, both in academic and community settings. Of course, patients always have a reason for presenting to the ED, but why seek out the ED (often multiple times) for chronic pain or other outpatient problems? Sometimes the Primary Care Physician’s (PCP) office is simply not open. More often it is something else altogether.

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Massachusetts Prescription Drug Monitoring Program (cont. from page 2)

To date, overdose deaths have been linked to PDMP profiles with daily doses of opioids at a morphine equivalence of greater than 20 mg/day. The risk of overdose deaths increases with higher daily doses and history of substance abuse or mental health disorders. No study has linked a number of prescribers, pharmacies, or prescriptions that can reliably indicate which patients are at risk of overdose.

The PDMP has provided another tool for us to assess patients, but at this point it raises more questions than it answers. Remember to use it in the full context of your patient evaluation and discuss the reports with your patients. Emergency providers usually write for short durations of opioid prescriptions and are unlikely to be the driver of prescription overdose, but we can be the driving force for better opioid stewardship, pain management, and referral to treatment for patients at risk of abuse and overdose.
Yet, very few emergency medicine physicians know that human trafficking exists, and could hardly imagine that these victims may present to Massachusetts emergency departments. One study of human trafficking survivors in the United States found that as many as 28% of trafficking victims present to health facilities during their captivity. Another study found that 11% of the Sexual Assault Nurse Evaluation (SANE) patients in their cohort met criteria for human trafficking. How often are victims of trafficking presenting to your emergency department and going undetected?

So, what is human trafficking? Human trafficking is modern day slavery. There are two primary types of trafficking: sex and labor trafficking. According to US law, anyone under the age of eighteen who engages in pornography or strip club work is considered to be a sex trafficking victim. Women of an older age in the sex industry are considered to be trafficked if there is an element of force, fraud, or coercion involved. Common examples of labor trafficking victims in the United States include migrant laborers or domestic workers who are coerced through insurmountable debts imposed upon them, threats of deportation, or having identification documentation withheld.

While the word trafficking connotes movement, the reality is that someone may be trafficked within their own home. They do not need to cross city, or even country lines.

“**In the same way that we are trained to identify rare but life threatening disease processes like aortic dissection, as emergency medicine providers we must understand the signs and symptoms of human trafficking.**”

Due to the force and coercion these victims undergo, they have health consequences that may be red flags in their identification. Many labor and sex trafficking victims are repetitively traumatized, both physically and sexually. Untreated STIs and pelvic inflammatory disease, sequela of unsafe abortions, and HIV/AIDS rates as high 60% have been described in the literature. Living conditions are often squalid and crowded, which places victims at higher risk for illnesses like tuberculosis and scabies. General malnourishment and repeated dental infections have also been reported. In addition, victims have high rates of drug and alcohol abuse, post-traumatic stress disorder and depression.

Nonmedical elements of their presentation may be tip-offs. These may include: discrepancies between history and injury pattern; lack of identifying documents; a mismatch between reported age and behavior; the presence of an overbearing man or woman accompanying the patient; or a fearful reaction to questions about a tattoo.

Based on your initial history and physical exam, you have a suspicion that a patient is a human trafficking victim. First, be sure that you are caring for his/her medical needs. The next step is to get more information about the patient’s situation. At this point, it may be reasonable to call upon a social worker. If the patient is accompanied by someone, be creative about separating them from each other so that you can

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Why Emergency Departments cannot be a Primary Care Provider
(cont. from page 3)

The Affordable Care Act (ACA) has prompted a debate surrounding the increasing rate of ED usage, which is outpacing population growth. Between 1997 and 2007, non-elderly Medicaid patients increased their utilization of the ED by 25% while ED usage by other patient populations remained constant. By 2011, 38% of Medicaid patients were seeking emergency care. Medicaid patients were twice as likely to use the ED each year and four times as likely to have multiple ED visits as their privately insured counterparts. In 2011, less than one-third of PCPs in the country accepted new Medicaid patients.

After the ACA takes effect, the nation’s ED census stands to swell radically with Medicaid’s eligibility expansion which will include approximately sixteen million additional people. If the past decade is any indication, the ACA may flood EDs with patients seeking an ED solution for ambulatory care-sensitive conditions. While approximately 61% of Medicaid recipients who repeatedly visit the ED report lack of timely access to their PCPs, less than half as many of their privately insured counterparts report facing this barrier. Not only is this surge of patients likely, it also is one that the EMTALA will compel us to treat.

“Higher reimbursement levels for services provided to Medicaid patients under the ACA must be implemented alongside other practice changes to ensure effective coverage of Medicaid patients’ ambulatory care-sensitive needs outside of the ED. Other changes should include improved communication between EPs and PCPs, new ED waiting room triage protocols, and extended business hours at primary care centers. Most importantly, collaboration with our primary care colleagues must increase in order to care for ambulatory care-sensitive without impacting the health of more critical patients.”

Human Trafficking (cont. from page 4)

speak to the victim alone. Consider talking to the patient while accompanying him/her to the bathroom or meet him/her in the radiology study room. Use a professional interpreter when there is a language barrier. Use language that reinforces his/her inner strength. Your goal is to establish further rapport with the patient as well as to gain information about his/her situation of exploitation.

So, what is an EM physician to do if, after obtaining further history, human trafficking is suspected? If the victim is under the age of 18, mandated reporting laws apply, and child protective services must be called. If the victim is over the age of 18, then offer whatever help the victim is willing to take. The ultimate goal is not necessarily disclosure or rescue. He or she may not be ready. It may be as simple as offering them the National Human Trafficking Resource Hotline 1-888-373-7888, or text BeFree (23337333). If the patient is ready to leave his/her situation, then your first call as a health provider is to this same hotline.

“The data indicate that all patients will suffer if the healthcare system as a whole simply treads water. Hospitals continue to close due to compelled treatment of an increasing group of the underserved, often uncompensated”.

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Next time you are updating your status on Facebook, pay some attention to the ads on the side of the screen. “Get RIpped in 2 weeks by using this one WEIRD trick” or “Try this WEIRD trick to lose 10 lbs of belly fat”. Interestingly, the trick is always “weird” and usually does not involve exercising more and eating less. Furthermore, “single moms” tend to be the ones who have discovered these tricks, and a certain professional subset (e.g. doctors, personal trainers, dieticians etc.) “hate her for it” according to the advertisement. Obviously, this is a scam and if you click on it and buy whatever they sell I consider it a tax on stupidity.

But not all issues are this clear cut. Let me explain:

Recently, I had a heart-breaking case in the pediatric ED of a child who had been constipated for a few days, and the mother had looked up online treatments for constipation after Miralax failed to do the trick. She discovered a recipe for sea salt in water that was supposedly the “natural way” to treat constipation. She created the tincture according to recipe and gave it to her child. The girl did have a bowel movement. The problem was that the girl had muscular dystrophy, received the salt water through her PEG, and could not ask for water when she became dehydrated from the treatment. She arrived in the ED seizing, with a wide-complex tachycardia, bowel necrosis, osmotic demyelination syndrome and a sodium level of 203. She died.

The emotional fall-out for the family was immense. In addition to losing their daughter, the authorities also removed two foster children who were in their care. These parents are good people, who meant no harm. They received bad advice from a website on the internet.

This is not the first time this issue presents itself. A family from Pennsylvania lost a child to pneumonia after guidance from their pastor resulted in choosing prayer over antibiotics. The parents were found negligent, and placed on probation. The preacher continued to preach. A few years later, the same parents (still attending the same church) lost their 8-month old son due to dehydration from diarrhea. They again chose prayer instead of seeking medical attention. This time, the parents went to jail. But the distributor of this treatment approach continues to preach. When a child dies, our reaction is to find someone culpable. But that is easier said than done. Is the author of a website or the preacher liable for providing potentially harmful information, or does the responsibility fall to the parents to filter through advice? After all, we live in a country where “caution: hot” is printed on coffee cups, so how much can we trust consumers to make reasonable decisions and not eat that desiccant silica package in the box?

The first amendment is a great idea. It states that congress can make no law restricting what you say. However, freedom of speech should not be freedom of consequence. If you yell “fire” in a crowded theater when there is none (or call in a bomb-threat at Harvard because you don’t want to take your final), you endanger the well-being of others and may end up in federal prison.

Editorial: Medicine and Social Media
By Eike Blohm MD
UMass Medical Center
Interestingly, when you are a B-category fashion model you can tell parents to not vaccinate their kids (to prevent the autism your child never had), you go unscathed even if the CDC MMWR finds that the measles cases have tripled as a consequence of lower vaccination rates.

In no way am I advocating a change to the first amendment - but I do think it is reasonable to establish a “cease and desist” legislature that once an advertised medical treatment (or avoidance thereof) that is broadcast in a public forum such as television, print media or online has been shown to cause significant harm, the broadcasting individual or entity either must include a warning or stop broadcasting.

After treating the girl in the pediatric ED, I went home and googled “Sea salt AND constipation”. I contacted the first 5 websites in the google search, told them about the patient I had seen and asked them to take down this information. I received no response. Two weeks later, the same information was still available without alteration.

While EM Advocate is a forum for Emergency Medicine residents in Massachusetts, the specific opinions expressed in each article are those of the individual author(s) and not necessarily of MACEP.

High Stakes Ethics in the Emergency Department

By Jolion McGreevy MD, MBE, MPH
Boston Medical Center

Emergency medicine is high stakes. A missed diagnosis can have such severe consequences that when it comes to clinical decision-making we strive for error rates that are vanishingly small. Ethical decision-making is also high stakes. Yet we devote too little attention to it. Failure to identify and respond to ethically-important moments can have terrible and long-lasting consequences: harm to patients, anger and guilt among families, and moral distress among health care providers. When we consider the stakes in emergency medicine, we need to think not only clinically, but also ethically.

Here are 5 tips for better ethical decision-making in the ED:

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At the end of a shift, as you are packing up and preparing to leave, your attending comes over for one last word. Maybe you shared a patient with a rare disease or maybe you were presented with an odd presentation of a common condition. But invariably the suggestion will be the same: “why don’t you read up on it when you get home?”

It is a request that has been made to generations of physicians, but in an age of endless electronic resources it has become more complicated. Where do you turn? To a textbook, UpToDate, or a blog post created by a second year medical student? In the past residents turned to text books or journal articles, now there are as many sources available as minutes in the day to read them.

It was this very issue that prompted Tim Peck, MD, a third year resident at Beth Israel Deaconess in Boston to create IClickEM and its parent company Parzival. At first he simply wanted a platform to store trusted sources of information that he and other emergency medicine physicians could use. His initial attempts proved unsuccessful when he realized he was in over his head. “I didn’t have the funding and I didn’t have the programming knowledge,” said Peck. That was until he met Lonnie Kurlander, a medical student at Boston University with a background in computer programming and business. Their meeting is when IClickEM really took off.

“I realized that it is answers that define groups, not questions” said Peck. “If an emergency medicine doctor has a question about COPD, the answers they are seeking are very different than those sought by a patient or family member with the disease or even an internal medicine or family practice doctor.” By making a search engine that is tailored to a specific field, with sources that have been vetted and are known to be trust-worthy, Peck hopes to streamline the search process to allow more time learning and less time looking. His team, which also includes Glenn Willen (formerly a Google engineer) and Celina Ansari, MD (a post-doc in Radiology at Stanford), has built a program that will rank different sources based on how often they are utilized for a given query. But how to make sure the information is trustworthy?

Before a source, be it a series of podcasts, a blog, or a product such as UpToDate will appear in the search results that source must be approved by the CAB, or Content Advisory Board. The CAB is comprised of such emergency medicine heavyweights as Michele Lin of *Academic Life in Emergency Medicine* and Mike Cadogan of *Life in the Fast Lane*. They have approved enough content to allow for beta testing to commence with 1,000 users. Once initial bugs are worked out it will launch for public use.

So next time you finish a shift and your attending suggests reading about the newest treatments for hereditary angioedema when you get home, look forward to a future when a quick search will find a relevant and reputable article, and you’ll spend more time learning (or sleeping…) and less time searching thanks to Tim.
High Stakes Ethics in the Emergency Department (Cont. from Page 7)

#1 Own the ethics

Clinical ethics is a core competency for all health care professionals. We must be familiar with the concepts, methods, and cases that mark the field. In one survey from the pediatric literature, more than 80% of nurses and physicians rated themselves somewhat to very knowledgeable about clinical ethics, but only about a third could correctly identify basic concepts: for example, that withholding and withdrawing life-sustaining treatment are ethically the same.

As in clinical care, best practices in ethics develop over time, based on the experience of many patients, families, and professionals. It may not have been obvious on our first ED shift that the middle-aged woman with indigestion needed an EKG. Likewise it may not be obvious why withholding treatment and withdrawing it once it's been started are ethically the same – and why this matters.

Suppose you intubate a patient with altered mental status and a few minutes later identify a massive hemorrhage on CT. The family arrives and hears the grim prognosis. They are sure that the patient would not want to live neurologically devastated on a ventilator but are reluctant to withdraw treatment. They feel they would be responsible for their loved one's death. The consensus view in clinical ethics is that withdrawing care is not 'killing,' but rather allowing patients to die from their underlying disease. We can initiate life-sustaining measures and subsequently withdraw them if it becomes clear that they don't align with the patient's goals of care. We must understand this and other key ethics concepts and be able to explain them to patients, families, and colleagues.

#2 Understand a range of perspectives

Clinical ethics is more than a collection of principles and famous court cases. It is a practice, which should be approached from a variety of perspectives.

We are all familiar with the four commonly used 'principles of medical ethics' (respect for autonomy, beneficence, non-maleficence, and justice). These principles are valuable but overused. One reason principle-based ethics is so popular is that it is easy to teach, but over-reliance on a handful of principles can cause us to miss important ethical obligations (Fiester 2007). If it fits on a single PowerPoint slide, it's probably not enough.

The need for a broader approach to clinical ethics is especially evident when we care for marginalized patients. The four principles are intended to serve as a universal standard, one that applies to all people everywhere. But universal standards almost always reflect the values of the privileged. Many patients find themselves — by virtue of their age, gender, race, class, ethnicity, education, immigration status, or any other social definition — left out.

A few alternative (and complementary) approaches to principle-based bioethics include narrative, case-based, virtue-based, and feminist bioethics. Take the time to become familiar with these other methods and be wary of any ethical analysis or guideline that relies too heavily on abstract principles.

#3 Be inclusive and ask for help

Ethical dilemmas by definition don't have a single solution.
When there’s genuine moral uncertainty, the discussion should include everyone — the patient, family, nurse, physician, and social worker. When a decision is especially difficult, a colleague with formal training in ethics, can be very helpful. People are often afraid to call the ethics committee. But we’re not on Capitol Hill. The ethics committee is not there to chastise us, rather to help us work through the tough ethical dilemmas.

That said, the recommendation of an ethics committee is not a mandate. There probably is no such thing as true 'expertise' in ethics. Every situation is different and, again, everyone’s experience and perspective matters. There are many solutions to all dilemmas, and what counts most is agreement among patients, families, and caregivers. Whether a decision is good may be more a function of the process than of the decision itself.

#4 Look for clues ethically-important moments

A grim prognosis is a clue to an ethically-important moment. The family of a patient who has no reasonable chance of recovery might want to withdraw care immediately, rather than see their loved one experience a prolonged death. Palliative care can begin in the ED. We need to be more comfortable discussing prognosis and goals of care rather than passing the responsibility on to others. Other clues to ethically-important moments are the pernicious labels that have become ubiquitous in medicine, especially in the ED. An example is the "difficult patient." While some behavior should not be tolerated, often patients act out because they feel mistreated, wronged.

#5 Watch for Moral Distress

Moral distress develops when we know the right thing to do but feel powerless to do it. Different situations cause different people moral distress, but so many high stakes ethical dilemmas arise in the ED that no one can going very long without experiencing it.

Nurses and physicians experience moral distress, for example, when they're forced to provide life-sustaining treatment that goes against a patient’s wishes or best interests. They believe they’re doing wrong by the patient but feel powerless to act do otherwise. Common barriers include unrealistic family expectations, power imbalances within the medical team, and fear of job loss or litigation. Unresolved moral distress is a threat to our integrity and can lead to anger, guilt, self-doubt, job dissatisfaction, and compromised care. The limited literature on moral distress suggests that while any health care professional can experience it, the impact is greatest on nurses. The next time a nurse tells you that they’re troubled by what they’re doing to a patient, listen carefully. Not only is this a clue to an ethically-important moment in the patient’s care, it’s an opportunity to do right by your team.

Medicine is fundamentally an ethical practice. We try every day to do good for patients, but we often face profound uncertainty about what counts as good, an uncertainty that will only increase as we discover more ways to exert control over life and death. Ethical decision-making can be especially difficult in the fast-paced ED. But it is imperative that we understand core ethics concepts and become as comfortable with high stakes ethical decisions as we are with clinical ones.
Clinical Case: Toxicology

By Stephanie Weiss MD
UMass Medical Center

I’m doing a shift in the Emergency Department with a first year medical student, and we sign up for a patient whose chief complaint is “first seizure.” The patient is an anxious 46 year old male accompanied by his wife. He reports a few months of blurry vision, shakiness, and imbalance; his new complaint is the seizure. His exam is notable for tachycardia, diaphoresis, akathisia, rigidity, and mydriasis. The rest of his neurological exam is normal, including his visual acuity and gait. He looks like he’s high on cocaine or amphetamines, both of which he denies using. But I’m a budding toxicologist on my med tox rotation, and the top of my differential is still a sympathomimetic overdose.

The patient’s labs are normal except for hypokalemia and some mildly elevated liver function tests. His initial EKG shows sinus tachycardia at a rate of 135 with normal intervals. His CT head is normal. We call neurology, and they recommend an MRI, which is also normal. The neurology team admits the patient to their service, and he has an EEG pending.

My student and I remain very interested in this case. My interest stems from the possibility that this is a toxicology case. She is interested because everything is new at her stage of training. She peppers me with questions. I teach her about the main toxidromes, and we go through them one by one as we build a differential. We consider serotonin syndrome, but the patient has no clonus and denies taking any serotonergic medications. We agree that the patient is much too diaphoretic and has too clear of a sensorium to be anticholinergic. He denies drinking daily, making alcohol withdrawal less likely. His rigidity and akathisia could almost fit with an anti-dopaminergic kind of picture, but he’s not on any of those medications either.

The next day, I am back on the toxicology service. I check the patient’s chart and see that the neurology team has ordered a comprehensive toxicology screen. It comes back positive for venlafaxine, which is not on the patient’s medication list from last night in the ED. That’s kind of strange. Even stranger, my medical student finds an outpatient clinic note from earlier in the week that says the patient’s primary care physician had recently started him on paroxetine, which isn’t present on the comp tox screen. I tell my medical student that the patient probably had serotonin syndrome after all. But still, it’s quite mysterious.
Clinical Case: Toxicology (cont. from page 11)

I contact the neurology attending and convince her to consult toxicology, which means that I can do some more investigating on this case. The patient’s official medication list includes both venlafaxine and paroxetine, just like my medical student said. I call the patient’s primary care doctor, who tells me that the patient was indeed taking venlafaxine, but it was causing some bad side effects. The PCP’s plan was to have the patient taper the venlafaxine down to half the dose for three days while starting the paroxetine. Now I’m even more confident that the diagnosis is serotonin syndrome. I call the patient’s pharmacy. He has filled his paroxetine prescription but has not yet picked it up. That explains why paroxetine didn’t show up on the comp tox, but not why he would be having serotonin syndrome.

Now I go to the patient’s room. I ask his wife to step outside so that I can speak to him alone. He admits that he has been taking venlafaxine for the past year and didn’t want his wife to know. His dose was doubled a few months ago, after which the neurological symptoms he had told me about in the ED the previous day started worsening. Instead of tapering off the venlafaxine like his PCP suggested, he had abruptly discontinued the venlafaxine three days ago. I finally realize that he doesn’t have serotonin syndrome after all; he has an antidepressant withdrawal syndrome. (See Table)

There are several important lessons to be learned from this case:

1) Don’t forget that tox cases can include withdrawal syndromes as well as ingestions.
2) Speak to the patient in private when asking about sensitive topics, including mental health history. Don’t assume that even the patient’s spouse is privy to all of their personal information.
3) Listen to your junior team members. I would never have made the effort to dig deeper into this case if not for an innocent question about the patient’s medications by the first year medical student who was shadowing me.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mental Status</th>
<th>Visual</th>
<th>Tone</th>
<th>Other</th>
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<tbody>
<tr>
<td>Sympathomimetic Toxidrome</td>
<td>Paranoia, psychosis, agitation</td>
<td>Mydriasis</td>
<td>Increased, seizures</td>
<td>Hyperreflexia, diaphoresis</td>
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<tr>
<td>Serotonin Syndrome</td>
<td>Coma, agitation</td>
<td>Mydriasis</td>
<td>Increased (more in LE), clonus</td>
<td>Hyperreflexia, diaphoresis</td>
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<tr>
<td>Venlafaxine Withdrawal</td>
<td>Anxiety, lethargy</td>
<td>Mydriasis, blurred vision</td>
<td>Increased, seizures (rare)</td>
<td>Tremor, akathisia (rare), ataxia diaphoresis</td>
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<tr>
<td>Venlafaxine Side Effects</td>
<td>Anxiety, fatigue</td>
<td>Blurred vision</td>
<td>Clonus, seizures (esp in overdose)</td>
<td>Tremor, diaphoresis, akathisia (rare)</td>
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Do you want to write for the EM Advocate?
The EM Advocate is looking for intelligent, creative, and interesting articles to highlight resident thoughts and opinions throughout the Commonwealth of MA. Subject matter can include topics of social responsibility, interesting cases, scientific advances, emergency medicine subspecialty issues, grass roots activism, and opinions regarding public or hospital policies, etc. Please contact your residency’s MACEP representative or the Editor for opinions, ideas, and article submission. We look forward to hearing from you! Kristin Dwyer, MD Editor in Chief, EM Advocate

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