Smoking Cessation Study in a Community Family Medicine Residency Clinic

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Medical students are a vital element to Family Medicine. Without them, our specialty would have no future. As a medical student, I was mentored by a number of phenomenal family physicians whose guidance and influence impacted me in ways that were life-changing. They gave of their valuable time and resources to support a student who had very minimal knowledge about what it truly meant to be a physician. Because no one in my family worked in the medical field, I struggled to understand and balance the complexities of medical training. As a resident, my unfamiliarity with the field quickly became supplemented by my colleagues whose experience taught me that practicing medicine is about treating the whole patient. Their expertise went on to assist me in perfecting my clinical and coping skills that I still rely on to this day. Now, as a practicing family physician, I realize that it is my responsibility to “pay it forward” to the next generation of Family Physicians. The AAFP Foundation shares the same sentiments and focuses on increasing the number of trained Family Physicians by developing their ability to provide the full spectrum of quality care. They have provided an opportunity called Family Medicine Lead to support current medical students and upcoming family residents. This program’s components include 250 scholarships to attend the National Conference of Family Medicine Residents and Medical Students and, for a select 30 residents and students, participation in a year-long leadership development program called Family Medicine Leads Emerging Leader Institute. Those students and residents who are selected as Emerging Leaders will experience group leadership training immediately following the National Conference. They will also be assigned a Family Medicine mentor to guide them with the development of a year-long post conference project. What an exciting event for our motivated and enthusiastic young leaders to develop their leadership abilities!

To help our medical student members, the KAFP Foundation also provides supplemental scholarships to attend the National Conference. Held July 28-30 this year in Kansas City, the workshops, courses and events will attract medical students from all over the country. During the meeting, Kentucky’s resident programs will be conducting a joint recruiting effort to provide conference attendees information on residency opportunities in the Commonwealth of Kentucky.

This year I am talking to the Family Medicine Interest Groups at University of Kentucky, University of Louisville, and University of Pikeville about these types of options we have for students to become involved in our specialty.

Lisa Corum MD

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I completed my family medicine residency in 1989. I have had the opportunity to work in a variety of practices, including in Olive Hill and Morehead, and then back in Lexington. Now, nearly twenty-seven years later, I find myself at Bluegrass Community Health Center. I have been here for almost six years, and I remember thinking to myself before I started working, “One of my biggest fears about taking this position is not being able to help these patients.”

The need is great. We began as a migrant farm worker clinic, so some of our patients do not speak English, have minimal possessions or live in substandard housing, and send what little they make back to their families in Mexico or places further south. We also have a homeless grant working with individuals who may be sleeping on the street, in their cars, in shelters, or “couch hopping” wherever they can find a willing friend, relative, or mere acquaintance. Imagine carrying your few belongings in a backpack that goes everywhere you go. The idea of taking a simple shower causes severe anxiety, because you might close your eyes and all of your possession could disappear. Then there is the violence, mental health, and unmanaged chronic diseases that you face daily. For those who are managing to the best of their abilities, it makes me wonder how they can keep their heads above water when unexpected circumstances like influenza strikes resulting in nine days off work. One day off work creates hardship, but nine days off work makes it impossible to pay rent, buy food, or pay the water bill that month. You then face the issues mental illness and substance abuse bring about that are, at times, extremely overwhelming for both the patient and myself. The reality is that there is not a place to refer an undocumented Hispanic boy with ADHD and behavior problems, or a diabetic, borderline, bipolar patient who has burned all the behavioral health bridges in the city and surrounding counties.

So first, I had to realize that there are things we can do, that I can do.

Transportation vouchers, food banks, emergency shelters, outreach to the farms and the homeless shelters, and, I am happy to say, an extensive list of services and resources are all avenues that allow many of our patients to continue to cope with life. We learn about new opportunities weekly. The more we reach out, the more we discover partnering organizations that add a level of service for our patients—eyeglasses, medications, job training, dental care. I would be remiss if I did not mention that the Affordable Care Act has been a Godsend to many of the patients we see. My, they certainly struggled before that law was enacted.

So why am I writing about this? In the last few years while working with my patients, I have gained an incredible amount of respect for their ability to face the barriers that make it a struggle just to live. As a result, I am frequently frustrated and even appalled at the stigmas these individuals face. Recently, I saw a patient who was hospitalized for a severe skin infection. He had fallen at work, had a significant wound, was not improving at his local hospital, and was subsequently sent to Lexington for specialty care. He was discharged and went to stay with friends in town. He was sent home on an antibiotic (linezolid) that required monitoring and was given the following instructions: 1) find a PCP to monitor your blood counts and 2) follow up with Infectious Disease in three weeks.

This was problematic for this patient because he did not have a PCP and did not understand that he was to follow up with a specialist. He began to call around. We are a relatively small clinic and are frequently challenged with not having the necessary number of providers to see all the patients who request appointments. This patient explained that he needed an appointment because he had been discharged from the hospital and instructed that a follow-up was required for the medication he was taking. This was a new patient. Although all of our slots had been filled that day, our clerical staff had been taught that a hospital follow-up requires more creative scheduling. The receptionist asked the RN who in turn asked me what to do, and I responded with, “Yes, we can see him. Have him come now.”

As it turned out, the patient initially saw a student. She did the initial interview, physical exam, and created an assessment and plan. I subsequently saw the patient, extracted additional information that I shared with the student, and we both completed our plan before discharging the fellow. As part of this learning session, the student and I met with our Quality Manager. He asked the student, “So, did you see anything interesting, today?” Her response was along the lines of, “Not really, just another drug addict with MRSA cellulitis who was in for a hospital follow-up, like all the other patients we see.”

The information I received from the patient revealed that he had recently discovered that he had Hepatitis C and never used IV drugs. He used cocaine ten years prior but did not currently use any substances except tobacco, had multiple tattoos, and his injury occurred at work but was not improving on its own. “Drug addict” was not on my list of problems.

It makes me question whether the patient was thinking, “She’s treating me like I’m a drug addict.”
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I would have much preferred discussing the ways to improve this patient’s transition from inpatient to outpatient care, or how to improve access to care, or care coordination so he could keep his follow-up appointment with Infectious Disease of which he had no knowledge concerning. I was disappointed by the label he was unfairly given.

This reminded me of another incident, about 3 or 4 weeks earlier. I was meeting with an administrator of a local hospital, trying to work out ways to help us know when our patients are seen at or admitted to the hospital. Again, transitions of care, the buzz word du jour. This may be particularly difficult if we don’t know the who, when and where of those transitions. During our meeting that included several members of my staff and the hospital staff, the administrator asked, “So, can you tell us the names of some of your frequent flyers? Maybe then we can tag their charts and notify you when they come in.” I was taken aback. I didn’t think they would come in.” I was taken aback. I didn’t think we used terms like “frequent flyer” given that it could be perceived as derogatory. And this was a hospital administrator in front of my staff. After the meeting, we were talking about what we had learned, and one of my staff members also used the term, “frequent flyer.” That reminded me, and I told them all, don’t say that. Patients would not like it and therefore it should not be used.

Would you use that term to describe a patient if he was standing in front of you?

Many of our patients are identified as high utilizers of emergency services. One of our Bhutanese families was struggling because their baby had frequent hospitalizations for seizures. The child did well on medication, but the parents could not get refills from the pharmacy when needed. Once we realized where the problem was, one of our staff members took responsibility for calling the pharmacy to see if the medication was ready at the appropriate times. It took a few months, but the family and the pharmacy can now communicate and the child has had no more seizure episodes. The frequent ER visits and hospitalizations were a result of language and cultural differences and not due to the parents’ actions. I may be wrong, but “frequent flyer” sounds like the patient is choosing the ER over other options. Maybe there isn’t a choice for that patient.

Even if it is not said in front of the patient, they still get the message. I am probably as bad about this as anyone, letting my fatigue and frustration show in the exam room. I would say, however, that one of the proudest moments of my medical career occurred about 12 months ago. We were meeting with some folks from the Fayette County Drug Court. They work with individuals who have a drug related criminal offense and, rather than staying in jail, receive intensive counseling and monitoring through the courts. Some of those individuals are addicted to opiates and they see us for drug assisted treatment for their addictions. One of the case managers told us, at this meeting, that his clients really liked working with us because “we did not treat them like they were addicts.” I was so proud of my staff for this. Isn’t that what we are supposed to do?

So, there are things that we can do for our patients. I am more than over my “biggest fear” when I started this job. But I have learned more than just that. Patients really do want you to hear them. I am thinking of a couple of my most challenging patients, folks that have run the gamut of being late, nonadherent, lost to follow up, abused and self abusive, disruptive and more. From these folks I have heard things like, “I feel safe here” or “You really do listen” or “Your staff cares about me.” Okay, maybe they say that because we tolerate all the baggage that comes with them…or maybe they say that because we accept them where they are. Can we help them move towards better health? Maybe. I hope so.

Many of us work with students. Remind them that many, perhaps most, of our patients have not had the resources we have had. Or they have been burdened with tragedy, a family tree of abuse or mental illness, or poverty and neglect. Or maybe just bad luck. Who are we to judge? Perhaps our colleagues need to be reminded of that as well. All I know is that I am nearing that part of my career when I am beginning to think of some of these folks do so much more for me than I do for them. Mostly I get to listen and let the patients tell me what they need…and that seems to help them the most.
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Smoking Cessation Study in a Community Family Medicine Residency Clinic

Introduction

Smoking rates in Kentucky consistently rank among the top in the United States. National anti-smoking campaigns and interventions have proven ineffective in significantly reducing the percentage of smokers in this state, and more importantly in Henderson, Kentucky where the patient population of smokers is disproportionately high when compared to other parts of the country. The overall smoking rate among adults in Henderson County is 26%, which is twice the national average of 13%. Often, these patients find themselves in the physician’s office due to a smoking related condition that could have been prevented with a successful smoking cessation intervention. Henderson County lies in an area where tobacco is readily grown and serves as one of the leading cash crops. Therefore, highly localized, historic, economic, and cultural factors have led to an excessive smoking rate in this community. As healthcare providers to this population, Doctors of Osteopathy (DO), residents, and employees of Methodist Hospital in Henderson sought to draw insight on the motivations and intervention points throughout the life of sampled cigarette smoking patients at the Methodist Hospital Continuity Care Clinic.

The focus of this initial study was to determine what behavioral and non-behavioral factors influence cigarette smokers to attempt cessation. In subsequent studies, interventions could be designed based on the direction provided by patients during this smoking characterization project. In addition, with the ability to develop subsequent research studies and implementation based on the results of this study, this project could continue beyond a descriptive format to an intervention and correlational phase specific to the needs of the local community.

Methodology

Sample

Participants in the study included a sample of 300 patients who sought care at Methodist Hospital’s residency clinic. The sample represented a mostly white, female population between 20-64 years of age, with a high school education who smoked cigarettes on a daily basis. Inclusion criteria included those who sought care at the residency clinic and wished to participate. Exclusion criteria included those outside the age range, non-smokers, and individuals who did not wish to participate in the study. Additionally, potential participants were not recruited and did not receive monetary compensation related to the study research design.

A descriptive study design with a convenience sample and quantitative approach was used to address the research question, “What factors, behavioral and non-behavioral, influence cigarette smokers to attempt cessation?” Participant data was self-reported and submitted to DO Residents in a clinical setting. Descriptive statistics were used to identify the sample population and to analyze the study results. Beta testing was conducted on 50 patients as a pilot study prior to full study implementation between February 2013 and April 2013. The authors of this study chose a goal of 300 surveys given their available resources. A core question essential to the study asked, “How many times in the past 12 months have you tried to quit smoking?” The top two reasons to quit smoking were statistically manipulated to make assumptions about the participants and these findings would be beneficial for the development of an intervention by DO Residents at a later date.

Instrument

Survey questions were partially derived from the Minnesota Adult Tobacco Survey (MATS) and the 2010-2011 Tobacco Use Supplement to the Current Population Survey (TUS-CPS) regarding cigarette usage and efforts to quit cigarette smoking. The MATS was developed for Minnesota residents to examine change towards the reduction of smoking cessation. It includes items associated with physical and mental health, psychosocial factors, and alcohol attitudes regarding smoking, exposure to secondhand smoke, and the impact on the perception of policies on smoking behaviors to support policy development. The 2010-2011 TUS-CPS is a National Cancer Institute (NCI) sponsored survey of tobacco use that has been administered as part of the US Census Bureau’s Current Population Survey beginning in 1992. The Centers for Disease Control and Prevention (CDC) was a co-sponsor with NCI from 2001-02 through 2006-07. The TUS-CPS is a key source of national, state, and sub-state level data from U.S. households regarding smoking, use of tobacco products, and tobacco-related norms, attitudes, and policies. It uses a large, nationally representative sample that contains information on approximately 240,000 individuals within a given survey period. Research derived from this instrument contributes to monitor/control tobacco programs and to conduct tobacco related research. Methodist Hospital survey questions were extracted from both substantiated instruments to address the research question aimed at identifying behavioral and non-behavioral factors associated with smoking and smoking cessation. Attempts at smoking cessation questions were identified by product, support groups, and other resources. Participants were also questioned regarding factors associated with cigarette cessation success/failure as it pertained to their primary healthcare provider.

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**Procedure**

The study was implemented at a Residency Clinic which is a free standing medical facility owned by Methodist Hospital and operated by Methodist Hospital staff and DO Residents. The survey was handed out to all adult patients at appointment check-in. Sampling continued until we met the goal sample size of 300 surveys. Informed consent was implied if individuals chose to participate in the study. Surveys were completed in the waiting room prior to DO Resident contact. It was estimated that survey completion would take approximately five minutes. Upon completion of the survey, the participant brought the survey into the exam room for DO Resident/patient review and discussion as appropriate. The DO Resident placed the completed surveys in a locked drawer. When sampling size was met, the Principal Investigator submitted the hard copy to the National Center for the Analysis of Healthcare Data (NCAHD) for data entry and analysis. All research team members were certified in the protection of human rights. The study was approved by the Methodist Hospital’s Institutional Review Board.

**Results**

Of 300 collected surveys, 265 were analyzed by the NCAHD. The 35 surveys were excluded because, either the patient was not a smoker, or the survey was incomplete. The largest percentage surveyed was aged 50-54 years (age range 20-65). Participants were predominately female (60.5%), Caucasian (81%), holding a GED/High School Diploma (44%), while 23% had some college and 23% did not graduate from high school.

Smoking history revealed that 57.5% of participants admitted to current daily smoking and 12.3% admitted to smoking on some days of the week. Of those that admitted to daily smoking, they smoked an average of 14.4 cigarettes per day, over one half pack. The average age of smoking onset, even just a few puffs, was 15 years, but smoking became a regular habit at an average of 17.2 years of age. Results showed that those surveyed had tried to quit smoking an average of 7.2 times in their lifetime, but the average number of times they had tried to quit in the last 12 months was only 0.7. **Figure 1 illustrates the average attempts at cessation by age group.**

Participants were also asked about current smoking cessation tool awareness. The largest percentages were aware of the use of nicotine gums and nicotine patches as smoking cessation resources. Although most participants had successfully achieved cessation by “quitting cold turkey,” the patch and gum were the most accessible methods for cessation of those surveyed. The third leading cessation tool participants were aware of included prescriptions like Chantix® (varenicline) or Wellbutrin® (bupropion); however, many had not tried these medications secondary to expense. **Other cessation tools and percentages are illustrated in Table 1.**

Smokers were asked to rank the top three factors associated with attempting cessation. Of the self-reported findings, 44.2% ranked smoking as being “bad for their health” as the top factor. “Expense of smoking” (20.1%) and smoking being “bad for family’s health” (19.3%) were the second and third ranked factors. The following ranked factors included: “family member/friend’s death associated with smoking” (5.07%), “other (did not fill in the blank)” (3.86%), “smoking not allowed in their workplace or public” (0.97%), and “advertisements encouraging people to stop smoking” (0.72%).

Participants surveyed were also asked to identify the top three factors that hindered them from smoking cessation. The number one factor (22.6%) included “overcoming the nicotine addiction.” A close second (20.9%) was “smoking had simply become a habit.” The third factor chosen was that smoking helped participants “deal with stress” (20.4%). Other factors chosen that hindered cessation attempts included: “close association with other smokers” (7.3%); “no access to cessation aids” (4.6%); “fear of failing at maintaining cessation” (3.5%); “needed more information on how to quit” (1.4%); and 0.3% reported “no family support.” Of those surveyed, 8.4% did not want to attempt cessation.

Participants were asked if they had a routine healthcare provider. 101 participants answered “yes,” while 130 answered “No.” Of those that answered “Yes” to having a routine healthcare provider, 82 said that they had been advised to quit smoking by their routine healthcare provider. After being advised to quit smoking by their healthcare provider, only 44% attempted cessation.

**Strengths and Limitations**

Sample size, the length of the survey, and the question format were considered as strengths of this study. Beta testing alleviated confounding variables associated with the methodology prior to initiation of the study. Additionally, having the data analyzed by the NCAHD provided accuracy and clarity of the results. Residents were exposed to primary-based research, which may impact independent practices at the conclusion of the residency training.

This study had a narrowed socioeconomic status, as it was affiliated with a freestanding medical clinic providing care at no charge to the uninsured, which limited the patient socioeconomic demographics. Results may also have been different if the sample were more diverse, as it was a mostly female Caucasian population. The survey question that asked participants if they had a routine healthcare provider was also a weakness, as most of the participants answered no, which affected the questions that followed. These participants were surveyed in the family medicine clinic where they see a routine family physician, but yet, still answered they did not have a routine healthcare provider. Lastly, data was collected only in Henderson County, Kentucky; therefore study results cannot be generalized beyond this geographical location.

**Comments**

Smokers often find themselves in their healthcare provider’s office with health related conditions secondary to smoking. By investigating both behavioral and non-behavioral factors associated with a person’s decision to attempt cessation and/or remain successful at cessation, information may be applied to subsequent studies. Interventions can be directed at current smokers or at vulnerable populations before smoking becomes a regular habit. Additionally, this study illustrates that healthcare providers are

continued on page 16
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advising patients to quit smoking, but not necessarily at every visit. Assessing smoking history and habits during every routine health visit will allow patients to ask questions and be provided with pertinent information on cessation aids and other available resources.

An innovative approach to adapt patient interventions within the catchment area in a real-time environment is thought to create more effective smoking cessation results. This community-based, patient-centered research study also establishes processes that can be widely replicated in other areas with a high percentage of smokers. As smoking-related illnesses are prevalent enough to weigh heavily on the national healthcare system, designing smoking cessation strategies at the patient level can improve overall health outcomes and lower expenditures.

References

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Heat Illness

“A 27 year old otherwise healthy male on no medications reports to your clinic after being transported by coworkers for heavy sweating, confusion and vomiting. His coworkers were concerned because he looked pale and felt hot. He is a blacktop paver and it is very hot outside with a heat index of 102 degrees Fahrenheit. What is your diagnosis and treatment plan?”

**Introduction:**

Heat-related illness encompasses a broad spectrum of diseases that include milder forms such as heat edema, heat rash, heat exhaustion, and ranges to the most severe form of heat illness—heat stroke. Heat illness can affect any individual, from the most skilled professional athlete or recreational outdoorsman to individuals affected by homelessness or the elderly. Clinicians are starting to see an increase in heat-related illnesses, particularly heat stroke.⁴ One recent study indicates that there have been more heat-related deaths in the last five years compared to any other five-year span in the last thirty-five years.⁵ Furthermore, heat illness is the third leading cause of death among athletes in the United States.⁶ While there can be significant morbidity and mortality associated with heat related illnesses, this spectrum of disease is preventable. Recognition of risk factors and identifying early signs and symptoms of heat illness may help prevent the progression to heat stroke.

**Presentation:**

**Table 1**

<table>
<thead>
<tr>
<th>Heat Illness</th>
<th>Symptoms</th>
<th>Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise-Associated Muscle Cramps</td>
<td>Involuntary, painful contractions of skeletal muscle</td>
<td>Tachycardia and hypotension (1-3).</td>
</tr>
<tr>
<td>Heat Syncope</td>
<td>Orthostatic dizziness and tunnel vision usually during periods of acclimatization. Collapse with immediate response can occur</td>
<td>Orthostatic hypotension, tachycardia or bradycardia (1, 2).</td>
</tr>
<tr>
<td>Heat Exhaustion</td>
<td>Heavy sweating, altered mental status, irritability, headache, weakness, increased thirst, nausea, vomiting and diarrhea</td>
<td>Skin pallor, tachycardia, hypotension, rectal temperature &lt;104°F and oliguria (1-3).</td>
</tr>
<tr>
<td>Heat Stroke</td>
<td>Altered mental status, dizziness, hallucination, delirium, headache, nausea, vomiting, syncope, collapse, seizures, and irritability</td>
<td>Tachycardia, hypotension, hot skin, with or without anhidrosis, and rectal temperature &gt;104°F (1-3)</td>
</tr>
</tbody>
</table>
Risk Factors:
Many risk factors (see Table 2) predispose an individual to heat illness. The presence of multiple risk factors increases the likelihood of developing heat illness. Certain medications may make individuals more susceptible to heat illness as well (see Table 3). While the mechanisms of the medications differ, they affect the body’s ability to dissipate heat. Some medications inhibit sweating, some increase the body's heat production, and some interfere with the body’s response to dehydration and heat.

Definition:
Two factors primarily differentiate mild forms of heat related illness from heat stroke. These two factors are core body temperature and involvement of the central nervous system. Heat stroke is associated with a core body temperature greater than 104 degrees Fahrenheit, includes central nervous system impairment, and can cause other organ system failures. Moreover, milder forms of heat illness such as heat edema, heat exhaustion, heat rash, heat cramps, or heat syncope are associated with a core body temperature less than 104 degrees Fahrenheit and typically do not include central nervous system involvement. The central nervous system is briefly altered in individuals with heat syncope, however, it is important to note that their mental status and any other central nervous system abnormalities completely corrects with positional change. Other symptoms associated with milder forms of heat illness may include fatigue, nausea, vomiting, headache, dizziness, or weakness. Individuals with heat exhaustion may also present with profuse sweating and cold, clammy skin. While individuals with heat exhaustion have normal mentation, early recognition and treatment is important because the individual’s condition may progress to heat stroke.

“After reviewing this patient’s risk factors and obtaining a rectal temperature of 104 degrees Fahrenheit, you diagnose the patient with heat exhaustion. How would you treat this patient?”

Table 2
<table>
<thead>
<tr>
<th>Risk Factors for Developing Heat Related Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dehydration</td>
</tr>
<tr>
<td>Age (Younger than 15, older than 65)</td>
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<tr>
<td>Obesity (BMI greater than 30)</td>
</tr>
<tr>
<td>Poor physical fitness</td>
</tr>
<tr>
<td>Poor nutrition</td>
</tr>
<tr>
<td>Excessive clothing and equipment</td>
</tr>
<tr>
<td>Recent acute illness, particularly febrile illness</td>
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<tr>
<td>Lack of sleep</td>
</tr>
<tr>
<td>Pulmonary disease</td>
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<tr>
<td>Cardiac disease</td>
</tr>
<tr>
<td>Sickle cell trait</td>
</tr>
<tr>
<td>Sweat gland dysfunction</td>
</tr>
<tr>
<td>Gastroenteritis</td>
</tr>
<tr>
<td>Mental illness</td>
</tr>
<tr>
<td>Lack of acclimation to the heat</td>
</tr>
<tr>
<td>Prolonged exposure to the heat</td>
</tr>
<tr>
<td>Repeat exposure to heat in consecutive days</td>
</tr>
<tr>
<td>Skin conditions- Sunburn, Psoriasis</td>
</tr>
<tr>
<td>Previous heat illness</td>
</tr>
</tbody>
</table>

Table 3
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<tr>
<th>Medications/Substances That Increase Risk for Heat Illness</th>
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<tbody>
<tr>
<td>Alcohol</td>
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<tr>
<td>Alpha-adrenergic agonants</td>
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<tr>
<td>Antihistamines</td>
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<tr>
<td>Anticholinergics</td>
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<tr>
<td>Antidepressants</td>
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<tr>
<td>Antipsychotics</td>
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<tr>
<td>Beta blockers</td>
</tr>
<tr>
<td>Calcium channel blockers</td>
</tr>
<tr>
<td>Diuretics</td>
</tr>
<tr>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Illicit drugs including: cocaine, heroin, PCP, LSD</td>
</tr>
<tr>
<td>Laxatives</td>
</tr>
<tr>
<td>Thyroid replacement medications</td>
</tr>
<tr>
<td>Supplements with ephedra</td>
</tr>
</tbody>
</table>

Minor heat illness:
Muscle cramping is a common, relatively benign heat related illness in which passive stretching and oral isotonic or hypertonic fluid replacement generally relieves symptoms. If cramping is not resolved with these measures, intravenous (IV) isotonic fluid replacement is indicated and electrolyte lab work should be considered. Heat edema is treated with elevation of affected extremities, fluid with high salt content, and for patients who have slower recovery time, compression stockings can be used. Full recovery can take up to fourteen days in some cases. Diuretics should be avoided as they are ineffective in heat related edema and can be harmful by worsening volume status and by harming kidneys. Heat syncope should be evaluated closely to ensure there is no serious underlying cause. It generally improves with laying the patient supine, elevating the lower extremities to aid venous return, and moving the patient to a cool environment.

Heat exhaustion:
Treatment of patients determined to have heat exhaustion requires prompt recognition and action to prevent extended repercussions, progression to heat stroke, and associated with their body’s response to overheating.

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Heat Stroke

The first step in managing a patient suspected of suffering heat stroke is the evaluation of airway, breathing, and circulation. If a patient does not require life support measures or endotracheal intubation, then step two is conducting a prompt measurement of central temperature. If central temperature is 104 degrees Fahrenheit or greater or the patient is hyperthermic and has altered sensorium, then he or she should be treated as a heat stroke victim. Convective cooling by cold water immersion has been identified as the most efficacious means to reduce body temperature quickly and safely. Water immersion therapy requires personnel to monitor a patient to avoid potential drowning. Maintaining cooling using water immersion techniques may be limited by agitation, seizures, need for continuous heart monitoring, or other superseding needs. In these cases, patients should be transported directly to a hospital and cooled by either evaporative techniques or ice bags placed under arms and at the groin (areas of largest blood vessels) en route. All patients with heat stroke are to be transferred to a hospital after on-site cooling. In the hospital setting, they should be monitored for shock, gastrointestinal bleeding, seizure, agitation, rhabdomyolysis, hepatic injury, disseminated intravascular coagulation, respiratory failure, and myocardial injury and evaluated and treated appropriately.

Preventive Strategies

The elderly, children, persons with chronic diseases and on medications, athletes, and outdoor workers are at high risk for heat-related illnesses. Identifying these vulnerable patients is the key step in preventing heat-related morbidity and mortality. Many public health units have extreme heat alert systems during heat waves. Likewise, as primary care providers, family physicians should develop heat emergency response plans. Flagging the charts of high risk groups, developing a systematic plan with their team to check on the vulnerable patients, and directing them to a publicly accessible air conditioning system in their community are preventive strategies of paramount importance for family physicians to implement. Adequate hydration is crucial in preventing heat-related illnesses. Elders are prone to dehydration because of normal, age-related physiological changes, and extra care is needed to ensure adequate hydration. One practical strategy that can accomplish this is to ensure that the elders consume a minimum of fifty-seven ounces of fluids in small amounts throughout the day. Another approach is using an electric fan, a very cheap commodity for use during extreme heat, that increases heat loss by convection and evaporation methods. However, Cochrane review does not promote or refute the use of electric fans during heat waves.

Occupational workers should take short breaks from their hot working environment and rest in shady areas. Conversely, this alone does not prevent the heat-related illness. Using cooling methods, such as immersion in cold water and ingestion of crushed ice during short breaks, should be advocated as preventive strategies.

Athletes who engage in outdoor activities are another vulnerable population to heat related illnesses. American football carries the highest risk of heat stroke of any sporting event. A pre-season medical evaluation, which includes prior history of heat illness, increased body mass index (BMI), poor hydration, lack of acclimatization, poor fitness, and spinal cord injury, is essential in identifying the risk factors of heat illness. Heat acclimatization can be achieved by slowly progressing the intensity of exercise and phasing of the equipment in a hot environment, thereby providing time for adaptation for physiological changes. Clothing preferences should include light colors, loose fitting, and breathable fabric. Educating an athlete’s parents and coaches is an important factor in preventing heat related illness. Stimulants, such as caffeine, increase the metabolic rate and should be avoided. Athletes with a fever or any illness
including viral infections are at a higher risk for heat stress and should be kept out of play until they completely recover.13,14 Players should have easy accessibility to fluid intake at all times; fluids should not be limited to only designated water breaks. The aim of the hydration is to prevent body mass loss more than 2% and to keep the urine light in color.7,34 Recent studies have shown that adolescents and adults do not differ in their thermoregulatory response during exercise in the heat when adequate hydration is maintained.15 Generally 3.3 to 8.4 ounces of fluids every twenty minutes for nine to twelve years of age is sufficient to compensate for the sweat deficit during exercise as long as they are euhydrated before the game.15 The National Athletic Training Association (NATA) has published pre-heat acclimatization guidelines, and, as of 2011, only 2.5 percent of high school football programs are compliant with these guidelines.15

Wet bulb globe temperature (WBGT) is a standard tool accepted by the International Standard of Organization (ISO), the American College of Industrial Hygienist, and adopted by various sporting federations.36 The empirical index takes into account the measurement of two derived quantities, the natural wet bulb temperature and the globe temperature along with the air temperature, and claims to take into account the main heat transfer phenomena such as evaporation, convection and radiation.36 However, it is critical to mention that it does not take into account the effect of high humidity and low air movement.34,36 Various sporting bodies have their own recommended cut off values based on the WBGT index. For example, the American College of Sports Medicine (ACSM) has a cut off value of 90.1 degrees Fahrenheit for acclimatized fit and low risk individuals.34 However, several factors need to be considered such as the metabolic heat production, athlete morphology, acclimatization state, and clothing.34 Therefore, it is very hard to establish universal cutoff values which necessitates adequate preventive strategies as discussed above in all possible situations.34 While the WBGT index is ideal, the heat index chart developed by U.S National Oceanographic and Atmospheric Administration (NOAA) is more accessible for the public. It acts to measure the relationship between the air temperature and relative humidity and how a body perceives heat stress in that specific environment.9 The Occupational Safety and Health Administration Act (OSHA) has derived a modified index from the NOAA heat index chart by lowering the threshold at which the preventive strategies have to be initiated for employees at worksites (see web link below).

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