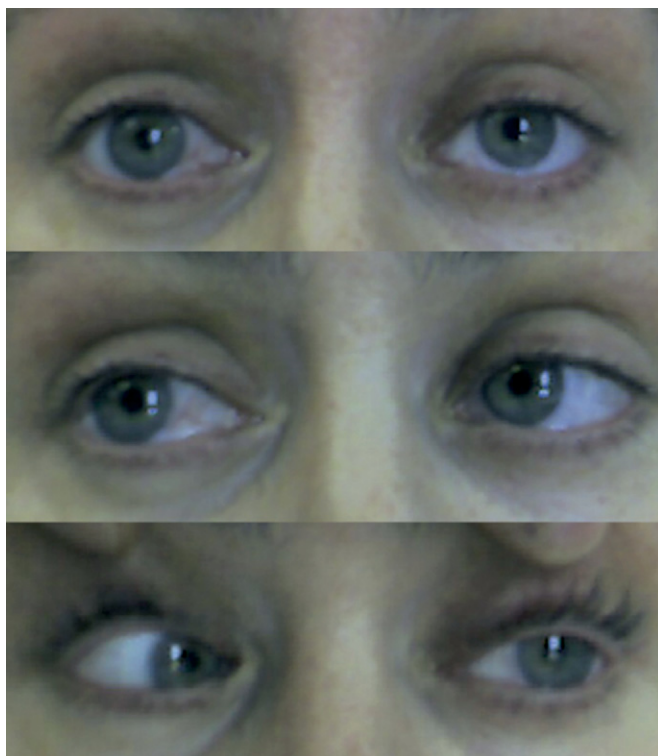


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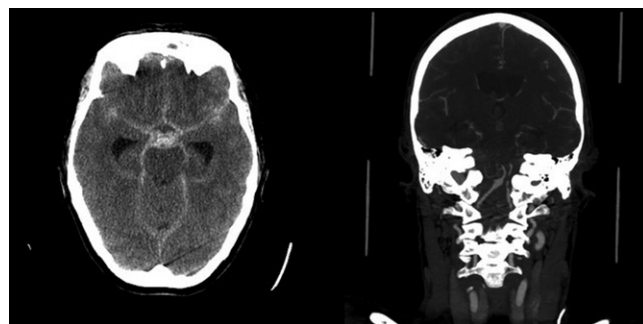
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**Figure 1.** The bottom photograph shows attempted left lateral gaze.

[Ann Emerg Med. 2009;53:690.]

A 44-year-old woman presented to the emergency department with neck pain. She reported that 1 week ago she “tweaked” her neck while coughing and during the intervening days had undergone physical therapy with massage for this mild, isolated neck pain. One hour before her ED arrival, the pain suddenly increased in severity, associated with vomiting and diffuse headache. The physical examination was notable for an inability of the left eye to abduct past the midline (Figure 1).



**Figure 2.** Computed tomographic angiogram of brain. Used with permission of Michael Halberg, MD, Maine Medical Center, Department of Emergency Medicine, Portland, ME.

*For the diagnosis and teaching points, see page 700.*

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and chief of emergency medicine at Detroit Receiving Hospital from 1969 through 1984" (page 5, para 1).

The "floater's log" was a compendium of problems identified by the floaters, physicians responsible for daily problem solving. "Floaters" were responsible for staffing, equipment needs and overseeing all patient care provided in the emergency department (ED).

The book, therefore, is a series of short stories describing everyday experiences of ED staff providing care at a large city-county hospital prior to the development of specialty residency training or academic certification by emergency medicine.

"We saw 100,000 - 150,000 patients each year, without regard to sex, sexual orientation, race or religion, or ability to pay. Laws mandating this didn't exist; we did it anyhow. Patients were transferred to us because they couldn't pay. Detroit was healing from the riots of 1967. Receiving, with a sixty year history of providing care to all comers, was, for better or worse, like a MASH unit in the ongoing battle to bring the Motor City back to life" (page 10, para 2).

Care was provided by any physicians who could be recruited to work in the "ER"; many were fellows in other specialty training programs. Floaters were to note which physicians arrived late or did not show up. Basic equipment (electrocardiogram machines or lab services) often were unavailable or malfunctioned. Security was inadequate and

fight occurred between patients and staff. One entry describes "another fire in room 1 yesterday" (page 26, para 2).

In the end the book is really more about Ron Krome, the person, than the specialty of emergency medicine. On first read one might think that a good editorial review would have "cleaned up" the script. This may have made the manuscript more "professional" or "correct" but it would not have reflected as much about the individual who wrote these words.

The book reflects the dedication of Dr. Krome and his colleagues to improve care, begin an emergency medicine residency and to establish academic status for emergency medicine. Their vision amidst the chaos of everyday life in the ED is one that holds true today as we struggle with crowding, diversion and inadequate staffing and resources.

Most emergency medicine residents and junior faculty have little understanding of the beginnings of our specialty. This book provides insights only previously available as anecdotes from physicians in practice 30-40 years ago. The stories are entertaining, informative and insightful. It is highly recommended reading for all of us who have benefited from the evolution of the specialty of emergency medicine.

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## IMAGES IN EMERGENCY MEDICINE

*(continued from p. 690)*

### DIAGNOSIS:

*Lateral rectus palsy from subarachnoid hemorrhage.* Lateral rectus palsy is present in 5.9% of patients with aneurismal subarachnoid hemorrhage.<sup>1</sup> This likely occurs because increased intracranial pressure compresses the abducens nerve during its course through the base of the brain, which is relatively long compared with the other cranial nerves.<sup>2</sup> When abducens palsy is discovered in the absence of injury, a range of processes should be entertained, such as subarachnoid mass, basilar meningitis, and increased intracranial pressure caused by pseudotumor cerebri or skull base neoplasm.<sup>3</sup>

Our patient had a vertebral artery aneurysm causing subarachnoid hemorrhage and her initial complaint of neck pain. Computed tomography of the brain revealed acute hemorrhage centered at the suprasellar and ambient cisterns (Figure 2). The patient's eye was covered to relieve diplopia and the neurosurgery team was consulted. Ultimately, transfer was arranged for neuroendovascular management.

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