

Viewpoint



Improve Your Response to Intimate Partner Violence with 10 Action Steps

By Ellen Taliaferro, MD, & Zita Surprenant, MD, MPH

Intimate partner violence (IPV), the psychological, emotional, and physical abuse of your patients by a current or former intimate partner, affects close to four million women a year. A little more than a third of these women report violent victimization. Like many other medical conditions, IPV often escalates in frequency and severity the longer it persists. For approximately 1,000 women each year, the violence becomes fatal.

Few of us in health care are comfortable dealing with IPV. Couple this with the fact that many physicians feel that *their* patients do not have family violence issues, and you end up with a devastating problem that goes unrecognized, unaddressed, and untreated.

The truth is that IPV presents a major challenge to physicians in every practice setting and specialty, and the after-effects of violence and abuse cast a long shadow on the patient's current and future health.

Early recognition of IPV and an appropriate response to IPV goes a long way in getting patients the help they need to be safe and escape ongoing injuries and illness. In addition, a valuable benefit occurs when the psychological and physical trauma of the abuse is addressed, laying the groundwork for the patient's improved health and well being.

IPV problems can appear at any moment in any practice setting. In light of this fact, physicians and health care providers can

Drs. Taliaferro and Surprenant's book, *Respond to Intimate Partner Violence—10 Action Steps You Can Take to Help Your Patients and Your Practice*, is available for \$29.95 through amazon.com and at www.vlh.com.



Dr. Zita Surprenant

improve care of IPV victims by implementing 10 Action Steps in their clinical settings.

The first section of our new book, *Respond to Intimate Partner Violence—10 Action Steps You Can Take to Help Your Patients and Your Practice*, provides guidance for recognizing and detecting IPV in the practice setting. Section two stresses the appropriate response to the identification of IPV by putting into place 10 action steps.

Action Step No. 1: Respond Effectively

When a patient tells you that IPV complicates her life, you have a unique opportunity to help improve her health and well-being. Support her in making changes by validating the difficulties and challenges she is experiencing as well as her need to make changes.

By validating victims and survivors of IPV, you give your patients a tonic more powerful than any prescribed drug. Validation occurs through therapeutic messages, listening, and providing support materials. Some therapeutic messages you tell the patient bear repeating several times during your time with the patient. Chief among these:

- "You do not deserve to be hurt, no matter what."
- "You are not alone; help is available."



Dr. Ellen Taliaferro

Listening nonjudgmentally is a therapeutic message in itself. Once you have validated your patient, you have her trust and can move to the next step in her care.

Action Step No. 2: Safety Needs

Start by determining how safe your patient is right now. There are numerous safety assessment tools you can use. One simple one is the physical abuse ranking score. Ask your patient if her partner does these things:

- Throws things, punches the wall.
- Pushes, shoves, or grabs her.
- Slaps her with an open hand.
- Kicks or bites.
- Hits with closed fists.
- Attempts strangulation.
- Beats her up (pinned to wall/floor, repeated kicks, punches).
- Threatens with a weapon.
- Assaults with a weapon.

If your patient's abuse ranking score is higher than five on this scale, your patient can be in extreme danger. Even if the abuse ranks low on this scale, however, your patient may still be in danger. Any patient who *feels* in danger should be considered to *be* in danger.

Safety planning for your patient should be tailored to conform to her needs. For instance, she may elect to stay in her relationship with her batterer because she feels that is safer than leaving at that time. Regardless of whether your patient elects to leave or stay with her batterer, she must not leave your clinical setting without a plan in place.

Action Step No. 3: Referral

Services available to help patients differ in each community. A fast call to the national domestic violence hotline, (800)799-SAFE, provides local

Continued on page 6

Continuing Medical Education in EMN

In this and every issue, *Emergency Medicine News* offers two CME activities: 1) InFocus, the clinical evidence-based column written each month by James R. Roberts, MD, and 2) Learning to Live with the LLSA, a review of the American Board of Emergency Medicine's Lifelong Learning Self-Assessment reading list by Daniel K. Mullin, MD.

Target Audience Statements: The InFocus CME activity in *Emergency Medicine News* is intended for emergency physicians with an interest in the diagnosis and treatment of various disease processes commonly seen in emergency departments, with special emphasis on evidence-based medi-

cine. The Learning to Live with the LLSA CME activity in *Emergency Medicine News* is intended for emergency physicians with an interest in studying for the annual American Board of Emergency Medicine's Lifelong Learning and Self-Assessment examination.

Accreditation Statement: Lippincott Continuing Medical Education Institute, Inc., is accredited by the Accreditation Council for Continuing Medical Education to provide medical education to physicians.

InFocus Credit Designation Statement: Lippincott Continuing Medical Education Institute, Inc., designates this educational activity for a maxi-

mum of 1 *AMA PRA Category 1 Credit*.TM Physicians should only claim credit commensurate with the extent of their participation in the activities.

Learning to Live with the LLSA Credit Designation Statement: Lippincott Continuing Medical Education Institute, Inc., designates this educational activity for a maximum of 1 *AMA PRA Category 1 Credit*.TM Physicians should only claim credit commensurate with the extent of their participation in the activities.

InFocus CME begins on p. 12

LLSA CME begins on p. 22

VOL XXX, No. 1

Editorial Board:

Chairman

James R. Roberts, MD
Mercy Catholic Medical Center &
Drexel University College of Medicine
Philadelphia, PA

William G. Barsan, MD
University of Michigan
Ann Arbor, MI

William Brady, MD
University of Virginia School
of Medicine
Charlottesville, VA

W. Richard Bukata, MD
San Gabriel (CA) Valley
Medical Center

Theodore Chan, MD
University of California
School of Medicine
San Diego, CA

Steven J. Davidson, MD
Maimonides Medical Center
Brooklyn, NY

Timothy B. Erickson, MD
University of Illinois Chicago,
IL

Jonathan Glauser, MD
Case Western
Reserve University
Cleveland, OH

Lewis Goldfrank, MD
Bellevue Hospital/NYU Medical
Center
New York, NY

Richard Hamilton, MD
Drexel University College of
Medicine
Philadelphia, PA

Richard Harrigan, MD
Temple University Hospital and
School of Medicine
Philadelphia, PA

Katherine Heilpern, MD
Emory University School of
Medicine
Atlanta, GA

Jerome Hoffman, MD
UCLA School of Medicine
Los Angeles, CA

Lawrence Isaacs, MD
Temple University School of
Medicine
Philadelphia, PA

David Karras, MD
Temple University School of
Medicine
Philadelphia, PA

Brent R. King, MD
The University of Texas
Houston Medical School
Houston, TX

Edwin Leap, MD
Oconee Memorial Hospital
Seneca, SC

Robert M. McNamara, MD
Temple University
Philadelphia, PA

Daniel K. Mullin, MD
Drexel University College of
Medicine, Philadelphia

Ash Nashed, MD
Columbia University College of
Physicians and Surgeons
New York, NY

Stephen Playe, MD
Baystate Medical Center
Springfield, MA

Jeffrey Selevan, MD
Southern California
Permanente Medical Group
Pasadena, CA

Earl Siegel, PharmD
Drug & Poison Information
Center
Cincinnati, OH

David A. Talan, MD
UCLA School of Medicine
Sylmar, CA

Ellen Taliaferro, MD
The University of Texas
Southwestern Medical Center
Dallas, TX

Peter Viccellio, MD
SUNY School of Medicine
Stony Brook, NY

David Wagner, MD
Drexel University College of
Medicine
Philadelphia, PA

Ron Walls, MD
Brigham and
Women's Hospital & Harvard
School of Medicine
Boston, MA

Shari J. Welch, MD
Salt Lake City, UT
Jennifer Wiler, MD
Washington University
St. Louis, MO

Published monthly by Lippincott Williams & Wilkins.

Editor: Lisa Hoffman

Editorial Assistants: Angela Munasque

Art Director: Kathleen Giarrano

Associate Director of Production: Barbara Nakahara

Production Associate: Nick Strickland

Desktop Manager: Peter Castro

Manager of Circulation: Deborah Benward

Circulation Associate: Fred Rella

Group Editor: Serena Stockwell

Executive Director of Continuing Education: Jay Magrann

Publisher: Ken Senerth

Executive Vice President, Journals Publishing: Matthew Cahill

Vice President, Executive Publisher: Ray Thibodeau

Director of Advertising Sales: Mike Guire

Manager of Advertising Sales: Martha McGarity

Advertising Representatives:

Breunung Nagle Associates
58 Pine Street
New Canaan, CT 06840

James L. Nagle
(203)801-0055
(203)801-0011 (fax)
nagle@BreunungNagle.com

James F. Breunung
(609)397-5522
(203)801-0011 (fax)
breunung@BreunungNagle.com

Classified Advertising:

Melissa Moody
351 W. Camden St.
Baltimore, MD 21201
(800)269-4339
(410)528-4452 (fax)



Emergency Medicine News (ISSN 1054-0725) is published monthly by Lippincott Williams & Wilkins at 16522 Hunters Green Parkway, Hagerstown, MD 21740. Editorial, business, and production offices located at 333 Seventh Ave., 19th Fl., New York, NY 10001; (646)674-6544; fax: (646)674-6500; emn@LWW.com. Printed in the USA. ©Copyright 2008 by Lippincott Williams & Wilkins. Periodical postage rates paid at Hagerstown, MD, and at additional mailing offices. Physicians who are registered with AMA/AAO as having a primary or secondary specialty related to emergency medicine, as well as SEMP members (within the U.S.), are eligible for a free subscription. To place an order, cancel a subscription, change your address, or for other subscription services, please call (800)430-5450, fax to (800)383-1781, or send an e-mail to emn@dmdata.com. (Please remember to include your current mailing address and specialty.) POSTMASTER: Send address changes to: *Emergency Medicine News*, 2340 River Rd., Ste 408, Des Plaines, IL 60019-9883.

No part of this publication may be reproduced without the written permission of the publisher. The appearance of advertising in *Emergency Medicine News* does not constitute on the part of Lippincott Williams & Wilkins a guarantee or endorsement of the quality or value of the advertised products or services or of the claims made for them by the advertisers. The authors, editor, and publisher have tried to ensure that the information, including drug selections and dosages, in this publication meet current recommendations. Readers are urged, however, to check the package insert of each drug for changes in indications and dosage and for added warnings and precautions. The authors, editor, and publisher are not responsible for any errors or omissions or for consequences from application of the information in this publication, which remains the professional responsibility of the practitioner.



IPV

Continued from page 4

resources that patients can access. Be sure to identify yourself as a provider at the very beginning of the call.

Most patients dealing with the presence of intimate partner violence in their lives don't need to be admitted to the hospital. If your patient has medical or mental health needs that require admission and her perpetrator remains free or poses a threat to her, consider admitting her as a Jane Doe. Note that HIPAA pro-

vides that patients can request not to be listed in the health care facility directory.

Action Step No. 4: Document

Good documentation builds a bridge of communication among health care providers attending the patient, and assists when community advocacy and legal referrals are indicated. When taking care of victims of IPV, the three main modes of documentation consist of charting, body maps, and photo documentation.

Action Step No. 5: Reporting

Mandatory injury reporting require-

ments vary considerably from state to state. To provide effective IPV intervention, you need to understand your state and local reporting laws, procedures, and the methods of enforcement, whether the issue is IPV, child abuse, elder abuse, abuse of someone with a disability, or assault involving weapons.

Specific information about state reporting laws can be found at www.end-abuse.org.

Action Step No. 6: Stage of Change

Change is not easy. Leaving an abuser or

staying in a relationship with new family dynamics often represents a major life change. You can best help your patient bring about necessary changes in her life by understanding that change occurs in stages and that relapse is a normal part of the process.

Action Step No.7: Special Populations

There can be additional barriers, special needs, and safety issues when working with IPV victims across age groups, gender, sexual orientation, and different cultures. You can best help individual patients in each of these groups by understanding the special needs each group has. For instance, a male victim of IPV struggles with issues different from a teenage girl being abused by her partner or an elderly widow who remarries and then finds herself a victim of abuse.

TYGACIL® (tigecycline) Brief Summary

See package insert for full Prescribing Information. For further product information and current package insert, please visit www.wyeth.com or call our medical communications department toll-free at 1-800-934-5556.

CONTRAINDICATIONS

TYGACIL is contraindicated for use in patients who have known hypersensitivity to tigecycline.

WARNINGS

Anaphylaxis/anaphylactoid reactions have been reported with nearly all antibacterial agents, including tigecycline, and may be life-threatening.

Glycylcycline class antibiotics are structurally similar to tetracycline class antibiotics and may have similar adverse effects. TYGACIL should be administered with caution in patients with known hypersensitivity to tetracycline class antibiotics.

TYGACIL may cause fetal harm when administered to a pregnant woman. If the patient becomes pregnant while taking tigecycline, the patient should be apprised of the potential hazard to the fetus. Results of animal studies indicate that tigecycline crosses the placenta and is found in fetal tissues. Decreased fetal weights in rats and rabbits (with associated delays in ossification) and fetal loss in rabbits have been observed with tigecycline. (See **PRECAUTIONS, Pregnancy**.)

The use of TYGACIL during tooth development (last half of pregnancy, infancy, and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). Results of studies in rats with TYGACIL have shown bone discoloration. TYGACIL should not be used during tooth development unless other drugs are not likely to be effective or are contraindicated.

Clostridium difficile associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including TYGACIL, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon leading to overgrowth of *C. difficile*.

C. difficile produces toxins A and B which contribute to the development of CDAD. Hypertoxin producing strains of *C. difficile* cause increased morbidity and mortality, as these infections can be refractory to antimicrobial therapy and may require colectomy. CDAD must be considered in all patients who present with diarrhea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents.

If CDAD is suspected or confirmed, ongoing antibiotic use not directed against *C. difficile* may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibiotic treatment of *C. difficile*, and surgical evaluation should be instituted as clinically indicated.

PRECAUTIONS

General

Caution should be exercised when considering TYGACIL monotherapy in patients with complicated intra-abdominal infections (cIAI) secondary to clinically apparent intestinal perforation. (See **ADVERSE REACTIONS**.) In Phase 3 cIAI studies (n=1642), 6 patients treated with TYGACIL and 2 patients treated with imipenem/cilastatin presented with intestinal perforations and developed sepsis/septic shock. The 6 patients treated with TYGACIL had higher APACHE II scores (median = 13) vs the 2 patients treated with imipenem/cilastatin (APACHE II scores = 4 and 6). Due to differences in baseline APACHE II scores between treatment groups and small overall numbers, the relationship of this outcome to treatment cannot be established.

Glycylcycline class antibiotics are structurally similar to tetracycline class antibiotics and may have similar adverse effects. Such effects may include: photosensitivity, pseudotumor cerebri, and anti-anabolic action (which has led to increased BUN, azotemia, acidosis, and hyperphosphatemia). As with tetracyclines, pancreatitis has been reported with the use of TYGACIL.

The safety and efficacy of TYGACIL in patients with hospital acquired pneumonia have not been established. In a study of patients with hospital acquired pneumonia, patients were randomized to receive TYGACIL (100 mg initially, then 50 mg every 12 hours) or a comparator. In addition, patients were allowed to receive specified adjunctive therapies. The sub-group of patients with ventilator-associated pneumonia who received TYGACIL had lower cure rates (47.9% versus 70.1% for the clinically evaluable population) and greater mortality (25/131 [19.1%] versus 15/122 [12.3%]) than the comparator.

As with other antibacterial drugs, use of TYGACIL may result in overgrowth of non-susceptible organisms, including fungi. Patients should be carefully monitored during therapy. If superinfection occurs, appropriate measures should be taken.

Prescribing TYGACIL in the absence of a proven or strongly suspected bacterial infection is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

Information for Patients

Patients should be counseled that antibacterial drugs including TYGACIL should only be used to treat bacterial infections. They do not treat viral infections (e.g., the common cold). When TYGACIL is prescribed to treat a bacterial infection, patients should be told that although it is common to feel better early in the course of therapy, the medication should be taken exactly as directed. Skipping doses or not completing the full course of therapy may (1) decrease the effectiveness of the immediate treatment and (2) increase the likelihood that bacteria will develop resistance and will not be treatable by TYGACIL or other antibacterial drugs in the future. Diarrhea is a common problem caused by antibiotics which usually ends when the antibiotic is discontinued. Sometimes after starting treatment with antibiotics, patients can develop watery and bloody stools (with or without stomach cramps and fever) even as late as two or more months after having taken the last dose of the antibiotic. If this occurs, patients should contact their physician as soon as possible.

Drug Interactions

Prothrombin time or other suitable anticoagulation test should be monitored if tigecycline is administered with warfarin. (See **CLINICAL PHARMACOLOGY, Drug-Drug Interactions** in full prescribing information.) Concurrent use of antibacterial drugs with oral contraceptives may render oral contraceptives less effective.

Drug/Laboratory Test Interactions

There are no reported drug-laboratory test interactions.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Lifetime studies in animals have not been performed to evaluate the carcinogenic potential of tigecycline. No mutagenic or clastogenic potential was found in a battery of tests, including in vitro chromosome aberration assay in Chinese hamster ovary (CHO) cells, in vitro forward mutation assay in CHO cells (HGPRT locus), in vitro forward mutation assays in mouse lymphoma cells, and in vivo mouse micronucleus assay. Tigecycline did not affect mating or fertility in rats at exposures up to 5 times the human daily dose based on AUC. In female rats, there were no compound-related effects on ovaries or estrous cycles at exposures up to 5 times the human daily dose based on AUC.

Pregnancy

Teratogenic Effects—Pregnancy Category D

Tigecycline was not teratogenic in the rat or rabbit. In preclinical safety studies, ¹⁴C-labeled tigecycline crossed the placenta and was found in fetal tissues, including fetal bony structures. The administration of tigecycline was associated with slight reductions in fetal weights and an increased incidence of minor skeletal anomalies (delays in bone ossification) at exposures of 5 times and 1 times the human daily dose based on AUC in rats and rabbits, respectively. An increased incidence of fetal loss was observed at maternotoxic doses in the rabbits with exposure equivalent to human dose.

There are no adequate and well-controlled studies of tigecycline in pregnant women. TYGACIL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. (See **WARNINGS**.)

Labor and Delivery

TYGACIL has not been studied for use during labor and delivery.

Nursing Mothers

Results from animal studies using ¹⁴C-labeled tigecycline indicate that tigecycline is excreted readily via the milk of lactating rats. Consistent with the limited oral bioavailability of tigecycline, there is little or no systemic exposure to tigecycline in nursing pups as a result of exposure via maternal milk. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when TYGACIL is administered to a nursing woman. (See **WARNINGS**.)

Use in Patients with Hepatic Impairment

No dosage adjustment is warranted in patients with mild to moderate hepatic impairment (Child Pugh A and Child Pugh B). In patients with severe hepatic impairment (Child Pugh C), the initial dose of tigecycline should be 100 mg followed by a reduced maintenance dose of 25 mg every 12 hours. Patients with severe hepatic impairment (Child Pugh C) should be treated with caution and monitored for treatment response. (See **CLINICAL PHARMACOLOGY, Special Populations, Use in Patients with Hepatic Impairment and DOSAGE AND ADMINISTRATION** in full prescribing information.)

Pediatric Use

Safety and effectiveness in pediatric patients below the age of 18 years have not been established. (See **WARNINGS**.) Therefore, use in patients under 18 years of age is not recommended.

Geriatric Use

Of the total number of subjects who received TYGACIL in Phase 3 clinical studies (n=1415), 278 were 65 and over, while 110 were 75 and over. No unexpected overall differences in safety or effectiveness were observed between these subjects and younger subjects, but greater sensitivity to adverse events of some older individuals cannot be ruled out.

ADVERSE REACTIONS

Because clinical studies are conducted under varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice. The adverse reaction information from clinical studies does, however, provide a basis for identifying the adverse events that appear to be related to drug use and for approximating rates.

Phase 3 clinical studies enrolled 1415 patients treated with TYGACIL. TYGACIL was discontinued due to treatment-emergent adverse events in 5.0% of patients compared to 4.7% for all comparators (5.3% for vancomycin/aztreonam and 4.4% for imipenem/cilastatin). Table 4 shows the incidence of treatment-emergent adverse events through test of cure reported in ≥2% of patients in these studies regardless of causality.

Table 4. Incidence (%) of Treatment-Emergent Adverse Events Through Test of Cure Reported in ≥2% of Patients Treated in Phase 3 Clinical Studies

Body System Adverse Events	TYGACIL ^a (N=1415)	Comparators ^b (N=1382)
Body as a Whole		
Abdominal pain	6.8	5.7
Abscess	3.2	2.6
Asthenia	2.5	1.7
Back Pain	1.2	2.3
Fever	7.1	9.8
Headache	5.9	6.5
Infection	8.3	5.4
Pain	3.7	2.9
Cardiovascular System		
Hypertension	4.9	5.6
Hypotension	2.3	1.7
Phlebitis	1.8	3.8
Digestive System		
Constipation	2.8	4.1
Diarrhea	12.7	10.8
Dyspepsia	2.9	1.6
Nausea	29.5	15.8
Vomiting	19.7	10.8
Hemic and Lymphatic System		
Anemia	4.2	4.8
Leukocytosis	3.7	2.5
Thrombocytopenia	6.1	6.2
Metabolic and Nutritional		
Alkaline Phosphatase Increased	3.5	2.6
Amylase Increased	3.1	1.4
Bilirubinemia	2.3	0.9
BUN Increased	2.1	0.2
Healing Abnormal	3.5	2.6
Hyperglycemia	1.8	2.9
Hypokalemia	2.1	2.9
Hypoproteinemia	4.5	3.0
Lactic Dehydrogenase Increased	4.0	3.5
Peripheral Edema	3.3	3.3
SGOT Increased ^c	4.3	4.4
SGPT Increased ^d	5.6	4.7
Nervous System		
Dizziness	3.5	2.7
Insomnia	2.3	3.3
Respiratory System		
Cough Increased	3.7	3.8
Dyspnea	2.9	2.7
Pulmonary Physical Finding	1.9	2.2
Skin and Appendages		
Pruritus	2.6	4.1
Rash	2.4	4.1
Sweating	2.3	1.6
Other		
Local Reaction to Procedure	9.0	9.1

^a 100 mg initially, followed by 50 mg every 12 hours

^b Vancomycin/Aztreonam, Imipenem/Cilastatin, Linezolid

^c LFT abnormalities in TYGACIL-treated patients were reported more frequently in the post therapy period than those in comparator-treated patients, which occurred more often on therapy.

In Phase 3 cSSSI and cIAI studies, death occurred in 2.3% (32/1383) of patients receiving TYGACIL and 1.6% (22/1375) of patients receiving comparator drugs; this difference is not statistically significant and relationship to treatment cannot be established. In all treatment groups, mortality was associated with higher baseline comorbidity and/or greater severity of baseline infections.

In Phase 3 clinical studies, infection-related serious adverse events were more frequently reported for subjects treated with TYGACIL (6.7%) vs comparators (4.6%). Significant differences in sepsis/septic shock with TYGACIL (1.5%) vs comparators (0.5%) were observed. Due to baseline differences between treatment groups in this subset of patients, the relationship of this outcome to treatment cannot be established. (See **PRECAUTIONS**.) Other events included nonsignificant differences in abscess (1.8% vs 1.6%) and infections, including wound infections (1.7% vs 1.1%) for TYGACIL vs comparators, respectively.

The most common treatment-emergent adverse events were nausea and vomiting which generally occurred during the first 1 – 2 days of therapy. The majority of cases of nausea and vomiting associated with TYGACIL and comparators were either mild or moderate in severity. In patients treated with TYGACIL, nausea incidence was 29.5% (19.6% mild, 8.5% moderate, 1.4% severe) and vomiting incidence was 19.7% (12.3% mild, 6.3% moderate, 1.1% severe). In patients treated for cSSSI, nausea incidence was 35.0% for TYGACIL and 8.9% for vancomycin/aztreonam; vomiting incidence was 20.0% for TYGACIL and 4.2% for vancomycin/aztreonam. In patients treated for cIAI, nausea incidence was 25.3% for TYGACIL and 20.5% for imipenem/cilastatin; vomiting incidence was 19.5% for TYGACIL and 15.3% for imipenem/cilastatin.

Discontinuation from tigecycline was most frequently associated with nausea (1.3%) and vomiting (1.0%). For comparators, discontinuations were most frequently associated with rash (1.1%), vancomycin/aztreonam) and nausea (1.0%, imipenem/cilastatin).

The following drug-related adverse events were reported infrequently (≥0.2% and <2%) in patients receiving TYGACIL in Phase 3 clinical studies:

Body as a Whole: injection site inflammation, injection site pain, injection site reaction, septic shock, allergic reaction, chills, injection site edema, injection site phlebitis

Cardiovascular System: thrombophlebitis, bradycardia, tachycardia, vasodilatation

Digestive System: anorexia, dry mouth, jaundice, abnormal stools

Metabolic/Nutritional System: increased creatinine, hypocalcemia, hypoglycemia, hyponatremia

Nervous System: somnolence

Special Senses: taste perversion

Hemic and Lymphatic System: prolonged activated partial thromboplastin time (aPTT), prolonged prothrombin time (PT), eosinophilia, increased international normalized ratio (INR), thrombocytopenia

Urogenital System: vaginal moniliasis, vaginitis, leukorrhea

Post-Marketing Experience

Worldwide post-marketing adverse events not previously listed in the product label include: anaphylaxis/anaphylactoid reactions, acute pancreatitis.

OVERDOSAGE

No specific information is available on the treatment of overdosage with tigecycline. Intravenous administration of TYGACIL at a single dose of 300 mg over 60 minutes in healthy volunteers resulted in an increased incidence of nausea and vomiting. In single-dose IV toxicity studies conducted with tigecycline in mice, the estimated median lethal dose (LD₅₀) was 124 mg/kg in males and 98 mg/kg in females. In rats, the estimated LD₅₀ was 106 mg/kg for both sexes. Tigecycline is not removed in significant quantities by hemodialysis.

This Brief Summary is based on TYGACIL direction circular W10521C002 ET01, revised 06/07.

Wyeth®

© 2007, Wyeth Pharmaceuticals Inc., Philadelphia, PA 19101 208875-01

ACTION STEPS FOR RESPONDING TO INTIMATE PARTNER VIOLENCE

1. Respond effectively to patients who disclose violent relationships.
2. Respond to your patient's safety needs.
3. Manage your patient's referral needs.
4. Document your findings.
5. Meet your state and local IPV reporting requirements.
6. Respond to your patient's stage of change.
7. Address IPV in special populations.
8. Address special clinical situations involving IPV.
9. Develop a system for addressing IPV in your practice.
10. Respond to abusers.

Source: Ellen H. Taliaferro, MD, and Zita J. Surprenant, MD, Virtual Lecture Hall of Medical Directions, Inc., 2006.

Action Step No. 8: Clinical Situations

In addition to separate populations, special clinical situations arise when treating IPV patients. For instance, the IPV victim and her perpetrator both may be your patients, or your patient may be suicidal. Another special situation arises when her abusive partner manually strangled her during an assault.

Action Step No. 9: Response System

You need a team approach to lay the groundwork for effective IPV intervention in your practice setting. Two critical ingredients set the stage for success:

- Provide training for your staff to



understand and respond to IPV.

- Designate a practice setting “IPV champion” who becomes your local expert on policies, procedures, and local resource coordination.

**Action Step No. 10:
Respond to Abuser**

Although your first concern must be the safety of the IPV victim who is not safe until the abuse and battering stops, you also must care about your patient’s abuser. Caring about IPV abusers can be a means of ending the abuse and ensuring the victim’s safety. Remember, even when vic-

tims leave their abusers and are safe, there is a high probability that their untreated abuser will victimize a new partner.

You can learn more about identifying IPV in your practice and preparing your practice setting for effective intervention in our book. The accompanying CD-ROM contains resources such as medical records forms, patient handouts, and even a staff training guide. The book can be ordered from the Virtual Lecture Hall of Medical Directions, Inc., or through amazon.com. (See box.) Online training with CME credits featuring the information in the book also can be

found at www.vlh.com.

Physicians and health care providers have a unique opportunity to identify and intervene with IPV in their practice settings. Doing so can save lives, promote patient health, and enhance a patient’s well-being. Los Angeles physician Bruce B. Ettinger sums this up quite well: “Set up a response system if one does not already exist, and take the risk and ask questions. The reward will equal anything you have ever done in medicine. You will save a life.” ^{EMN}

Dr. Taliaferro is an emergency physi-

cian and the medical director of the Keller Center for Family Violence Intervention at San Mateo (CA) Medical Center. Dr. Surprenant has served as a representative to the American Medical Association’s Education Committee of the National Advisory Council on Abuse and Violence, is active in family violence research, and is the lead author of the online CME program, Current Management of Domestic Violence: Responding to IPV (available at www.vlh.com). Please contact Dr. Taliaferro at ellent@mac.com for more information and resources about IPV.



when minutes count



FAAEM

Always means board certified.

To join now, contact the American Academy of Emergency Medicine at 800/884-2236. For additional information see www.aaem.org or contact info@aaem.org.