

common and comfortable position for pediatric patients. In the present cases, the CT findings demonstrated that the pressure point in Ihara's maneuver (midway between the xiphoid process and umbilicus) corresponded to the vertebral level of the pancreas (Fig. 2). The approach from the midclavicular line toward the spine allows us to avoid interference of the stomach body and to apply pressure by holding the pancreatic body between the physician's hand and vertebral body of the patient (Fig. 3).

There are several limitations to this study. The fact that the demographics of all the cases happened to be very similar may limit the generalizability of our findings.

In summary, we reported a novel method of pancreas palpation in children which may aid in the early diagnosis of pediatric AP.

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### A physician's (and private citizen's) right to privacy against internet data brokers: Maintaining safety in an unsafe profession



As an EM physician of 20 years, I have never felt as threatened by anything as I have by opportunists of the insidious electronic information superhighway. Looking back, I have had my life threatened multiple times. I have been told by a patient that he was going to get his gun and return to shoot me. I have been called every derogatory name that someone could come up with directed at people of Asian descent. I have had to jump out of the way of patients who were trying to assault me. I have had to hide out of sight from angry patients who threatened me with physical harm. And I have been hit, spat at and kicked while at work.

When I have called police to report threats to my life, my concerns have been belittled and discounted by police. Once I was told that I was being too sensitive and that the man who had threatened to shoot me with a gun was just drunk and didn't mean anything by his threat. I wondered how this same complaint would have been handled were it directed at another police officer or someone who was white.

Just being an ED physician puts me in harm's way. I regularly deal with psychotic patients, drug dependent individuals demanding narcotics, intoxicated people and anyone who is dumped in the ED by local law enforcement because having to choose between being taken to jail or dropped at the ED and released without charge is an easy choice. I deal with gang-related shootings, gang-related retaliations and people that are unstable or at their emotional lows. Being a minority adds another layer of risk, especially in my experience in rural settings where people are not used to dealing with people who are different.

I fully admit that I agreed to the job risks when I chose EM as my specialty. However, when I see all of my personal information appear on multiple websites, I am alarmed (Table 1). I never agreed to allow random individuals access to my phone number, home address, my relatives' names or my DEA number.

I am acutely aware of news reports of physicians who are killed by patients [1,2] as well as workplace violence in healthcare settings [3–5]. I feel particularly vulnerable working in an ED setting where violence is prevalent [6]. However, a recent case that caught my attention was a man who was driving from southern to northern California intending to kill three physicians [7]. He had two loaded guns as well as the home addresses of the doctors. While he was caught before his plan could be enacted, I surmised he must have obtained the doctors' home addresses from Internet data broker sites.

Data brokers allege that their data are pulled from public records and are therefore fair game to post. Instead they pool data from multiple sources (federal, state, local), collating court records, job information, real estate transactions, social media sites, links to family and friends, criminal records and financial information. (In my recent search, I was notified that I had "multiple criminal records," which I do not.) The information suspect or not is then combined into a single report. While they argue that the results are merely public records, I cannot believe that the public information was ever meant to be accessed in aggregate to potentially do harm to others merely because it can be co-located, given or sold outright to anyone who wanted it. Nor can I believe that the policy intent of the data was to facilitate en masse distribution.

Not surprisingly, the Internet offers some seemingly easy ways to mitigate the privacy intrusions. I could pay some of these websites directly to hide or remove my information (one website charged \$300). Or I could pay other websites that specialize in getting personal information removed. But why should I have to pay anyone to remove information that I did not expressly consent to have placed in the public domain? Let's face it. The world is an

**Table 1**

Ego surfing (the term denoting searching for oneself on a search engine) results over the years.

Year	Position	Search engine results
1998	Medical student	My name was referenced two times: - speaker in a local conference - free message board listing a rug for sale that I no longer needed
2003	Resident	One or two pages of references related to a book I had edited—mostly reviews and places where interested readers could potentially buy it
2007	Junior attending	Two or three pages about research articles that I had authored, corroborating my academic endeavors as an assistant professor while prior book references fell to the back of the search results
2018	Community physician	Over a dozen pages appeared. The first two pages were filled with personal information about me. Places that I had worked seemed to predominate. But then I began seeing what I would later find out are citations from “data aggregators” or “data brokers.” Unknowingly, I clicked one search result and it immediately reported my full name, home address, relatives of mine and multiple previous addresses. After a few more search pages, I found properties I had owned, my cell phone number, date of birth and DEA number.

unscrupulous place and paying to delete information another shouldn't have in the first place is extortion and criminal in my mind. All the worse if the data gathered were to be used to commit crimes against my family or me.

While I believe in transparency, I draw the line at my right for privacy and my personal safety. Thoughtful about my profession, I have always opted out of advertisements. I'm on the “do not call list.” I haven't joined social media. I believe that my right to privacy should take priority over anyone else's desire to have my information. I am not interested in having my identity stolen again (at least twice that I know of), being stalked or even killed by a disgruntled patient whom I refuse to prescribe narcotics using good medical judgment [8].

Physicians are trained to always consider patient safety above all. We constantly act to protect patients' personal information (HIPPA), safely do procedures, keep safe boundaries with patients and do no harm. Yet I am unaware of any federal laws that protect physicians in the same ways from these data brokers. As a private citizen, I believe that nobody should be subjected to this exposure of their personal lives unless they choose it. But this should be particularly true of a physician who works with the public in a high profile, potentially dangerous work environment. When a data broker can eliminate the delineation between my work life and personal information, a safety alert must be called to provide us federal protections.

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## Electronic health record triggered hepatitis C screening in the ED



With an estimated prevalence of nearly 2.4 million in the United States (US) and over 185 million worldwide, infection with hepatitis C virus (HCV) carries a significant burden on the health-care system [1,2]. In the US, upwards of 50% of affected patients are unaware of their diagnosis, putting them at an increased risk for progression to liver cirrhosis and subsequent organ failure [3]. With advancements in well-tolerated oral therapeutics, an increasing emphasis has been placed on early detection and routine screening practices. The Centers for Disease Control and Prevention (CDC) and the United States Preventive Services Task Force (USPSTF) recommend a one-time “birth cohort” screening for patients born between 1945 and 1965[4,5].

The Emergency Department (ED) plays an important role in the surveillance and detection of HCV infection. Existing literature supports the notion that HCV infected individuals are more likely to utilize the ED for care more than any other healthcare venue with an estimated ED prevalence rate of 4% to 18% [6–8]. Given this, the ED serves as a front-line resource in the early detection of HCV virus, particularly in the medically underserved population. Utilization of the electronic health record (EHR) to establish screening interventions has demonstrated effectiveness in cancer and viral screening in at risk patients in the ambulatory setting [9].

We conducted an IRB approved retrospective chart review to examine the utilization of our EHR to initiate opt-out testing of eligible patients for HCV screening in the ED. Descriptive statistics were used to analyze data.

Our tertiary care hospital is located in an urban setting with an annual ED census of roughly 93,000 visits per year. A build was introduced into our EHR that prompted the triage nurse to ask eligible patients if he or she had ever been screened for HCV in the past. Patients were deemed eligible for inclusion based on the registered date of birth in the EHR. Those born between January 1, 1945 and December 31, 1965 were included in the screening process. If the patient had not been previously screened, or was unsure, the EHR would prompt the nurse to place an order for a screening HCV antibody test. Positive antibody screening results would be automatically be forwarded to dedicated patient navigators who would attempt to arrange for confirmatory RNA testing and outpatient follow up with the Hepatology clinic (Fig. 1). These linkages to care efforts were supported by grant funding unrelated to this study.

During the six-month timeframe from June 1, 2018 to December 31, 2018, a total of 3023 patients visited our ED and met the