Letter to Editor
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Intensive Care: Turkey's First Subspecialty for Emergency Medicine

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Abstract

Diabetes mellitus is a disease that affects millions around the globe. It also comes with a major complication, diabetic foot ulcers. Lower extremities having little to no vascularity in diabetic people leads to wounds that are unable to heal on their own. These wounds later become infected and cause osteomyelitis, a condition in which the infection in soft tissues of the lower extremities spread to the bones of the foot. Charcot arthropathy is one of the more serious foot issues that can arise from diabetic neuropathy. The soft tissues, joints, and bones of the foot or ankle are all impacted by Charcot. The joints in the foot or ankle might dislocate when the bones deteriorate and become brittle. Diabetes patients who have their soft tissues and bones infected might even have to get their extremities amputated if not managed right on time. We describe the case of a 66-year-old man with type 1 diabetes mellitus who presented to the emergency department with increasing pain in the right foot. There was a hyperemic discharge coming out of his wound which increased gradually over time. The patient's been using Lantus and Novorapid and his blood glucose measurement at the time of admission was 466. Our patient said that he was hospitalized in the intensive care unit due to diabetic ketoacidosis 20 days before he applied to our emergency department, and his wounds, discharge, pain, and redness increased after this incident. We requested his anteroposterior and lateral radiographs of the right foot and a lower extremity CT. The scans were examined carefully and at last, amputation was recommended for the patient. The patient did decline our offer and wanted to go home with a dressing. Ampicillin/sulbactam and ciprofloxacin were started. We also recommended he see infectious diseases and plastic surgery consultants in the following days.

Keywords: Charcot arthropathy, Osteomyelitis, Diabetes

To the Editor,

Approximately 30 years after the acceptance of emergency medicine as a new and independent medical specialty in our country in 1993, we are now welcoming with great satisfaction, excitement, and happiness the establishment of the first sub-specialty of intensive care within the main branch of emergency medicine. "Intensive Care," the first subspecialty for emergency medicine, was approved by the Turkish Grand National Assembly on February 15, 2024, and the law was published in the Official Gazette on Friday, March 1, 2024, under the number 32476, officially coming into force (1).

In this significant achievement for our specialty, the Emergency Medicine Specialists Association (EPAT) has played a significant role, contributing through intensive care congresses with broad international content, translated and original intensive care literature provided to Turkish medicine, as well as intensive care, critical care, mechanical ventilator, and advanced cardiac and trauma life support courses and modules held in almost every city across the country. For many years, in some emergency departments of our country, intensive care services have been primarily provided to our patients by emergency medicine professionals, either as an independent department or within units with names such as "critical care," "emergency critical care," or "emergency critical intensive care" (2). As members of the intensive care working group of EPAT and as emergency medicine specialists who have been treating patients in two independent emergency intensive care units (totaling 13 beds) for emergency and critical patients in the emergency department of a tertiary-level training and research hospital in our capital city for about 10 years, we are both pleased and proud of this development. We recognize that the words "emergency," "urgent," or "acute" have become blurred and intertwined in critical patients or injuries (3). Both emergency medicine and critical/intensive care are influenced by similar dynamics in three important pillars: acute deterioration, quality resuscitation, and rapid, effective, and holistic approaches to multi-system dysfunction. The commonalities between them are more than we can imagine. It would be contrary to the natural progression of things if these two intertwined disciplines did not intersect one day. If we define intensive care as a discipline that utilizes all kinds of devices and advanced technology, especially artificial respiration, 24 hours a day to support the impaired functions

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of the body due to the temporary failure of one or more organs until the main cause is eliminated and to keep the patient alive, we can see how much it shares common goals with emergency medicine. Moreover, approximately one-fourth of the patients admitted to emergency departments require critical care, and this common patient population has become the most important reason for defining intensive care as a sub-specialty of emergency medicine in countries such as the USA, Canada, and Japan (2). To such an extent that even the concept of "Emergency Medicine" is now often referred to as "Emergency Medicine and Critical Care" in many places. Since any patient admitted to the emergency department is a potential candidate for critical care or intensive care, and since both emergency medicine specialists and intensivists do not have the chance to limit themselves to a single "organ," the importance and interrelationship of the two disciplines become clearer. Of course, the major difference between the two disciplines is that emergency medicine specialists also deal with minor diseases or injuries, whereas intensivists have almost no contact with this patient group (4).

As with any kind of development, progress, or change, various objections have arisen within the national medical community. The main arguments of these objections revolve around concerns such as the excessive number of specialties available to medical students, which may complicate the standardization of intensive care subspecialty education and quality, the potential decrease in preference for or interest in the intensive care subspecialty, the fear that emergency medicine specialists will transition to becoming intensive care subspecialists, and the concern that emergency departments across the country will be left empty, with emergency departments being provided solely by general practitioners. Many of these objections were found to be unwarranted, hastily made, and lacking in evidence, such as claims that interventional procedures in emergency medicine and intensive care are inherently different, or that intensive care can only be subdivided into categories like internal, surgical, or neurological, with emergency medicine falling outside of this framework. Additionally, some argued that our country's medical system, particularly specialty training, is more aligned with Europe than with the USA.While these objections could be addressed satisfactorily, demonstrating the reality of the situation and concepts, this article does not aim to do so due to space constraints and the intended focus.

The purpose of this article is to convey the satisfaction, happiness, and pride felt by emergency medicine specialists who have been delivering critical and intensive care services in emergency departments for nearly a decade, following a significant development outlined briefly above. We wish to share this sentiment with you, esteemed editor, and thereby with the esteemed readership of the journal.

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