

A Newsletter for the Members of the Kentucky Chapter - Winter 2026

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FAST Interpretation and the Lipliner Artifact: A Practical Update for Kentucky Emergency Physicians

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Emergency Medicine (EM) physicians are already familiar with the Focused Assessment with Sonography in Trauma (FAST) to rapidly identify intraperitoneal or pericardial free fluid and guide time-sensitive decisions. [1,2] There is an image processing error that EM physicians should be aware of as it can be confused with intraperitoneal free fluid.

Modern ultrasound machines and software increasingly strive for sharp, high-contrast images, relying on post-processing in order to improve border definition and image clarity. These adaptations are enacted to prevent speckling and result in clearer, crisp images. While these features enhance visualization, they can also introduce other limitations in image interpretation. One example is the “lipliner” which appears as a thin, symmetric, anechoic line that can be seen along the edge of solid organs (see attached image). The lipliner can be found along the caudal edge of the liver and at the splenic tip, precisely where free fluid is expected on a positive FAST examination, thereby creating the potential for false-positive interpretations. [3] Unlike true free fluid, which typically forms a wedge-shaped, dependent collection that tracks into tissue planes, the lipliner outlines the solid organ margin itself. It is a result of real-time adaptive filtering, rather than anatomy or pathology, and because it is a mathematic result, the lipliner is not technically a sonographic artifact. [3]

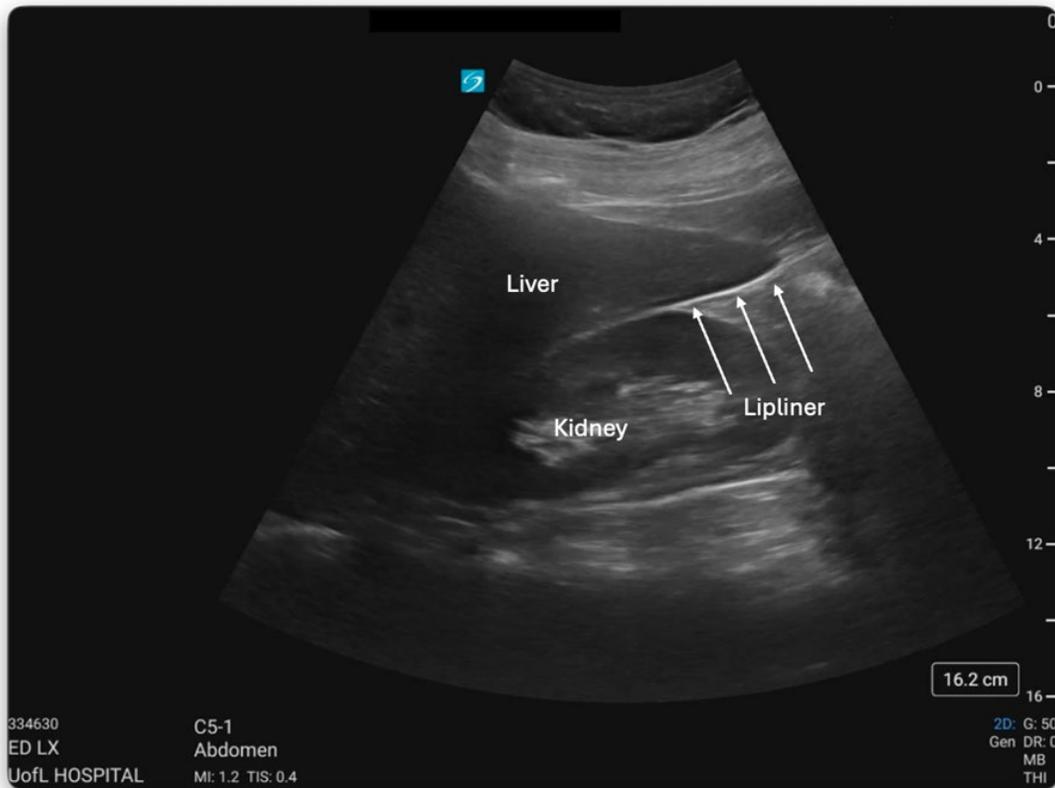
It is important for EM physicians to recognize and understand the lipliner. Machine vendors and POCUS leaders are working on machine presets that may preserve image quality and minimize the appearance of the lipliner. Consider looking again and adjusting probe positioning to clarify if the anechoic area is wedge-shaped and extending into potential spaces. Consider serial FAST exams. [4]

In addition to other well-known mimics of free fluid, physicians should expect to encounter post-processing errors introduced by modern ultrasound advancements designed to improve image clarity and usability. Understanding how these technologies influence image appearance is critical to accurate interpretation and informed clinical decision-making. Watch out for the lipliner when interpreting FAST scans on your next shift.

References

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3. Parker MA, Hicks BG, Kaili M, et al. The lipliner sign: potential cause of a false positive focused assessment with sonography in trauma (FAST) examination. *Journal of Emergency Medicine*. 2024;67(6):e553–e559.
4. Ferre, R. M., & Stolz, L. A. (2025, March 13). Lipliner artifact review. American College of Emergency Physicians, Emergency Ultrasound Section.

<https://www.acep.org/emultrasound/newsroom/march-2025/lipliner-artifact-review>



Lipliner sign (arrows): A thin, symmetric, anechoic line seen along the edge of the liver in this trauma patient. CT imaging was negative for intraperitoneal free fluid.

Senate Bill 12

When Kentuckians see the red letters spelling “EMERGENCY” on the side of a hospital, they reasonably expect that their care will be directed by a physician physically present at the bedside. SB 12 undermines that expectation and places patients, particularly those in rural and critical access hospitals. Just because someone does not live in Louisville or Lexington, doesn’t mean they do not deserve to see a physician in times of crisis or emergency.

Emergency departments are not clinics. They are where strokes, sepsis, trauma, airway compromise, and undifferentiated critical illness present without warning. These patients require immediate, on-site physician judgment, not remote availability by phone or video.

In many rural Kentucky hospitals, the emergency physician is the only physician in the building overnight. That physician is often responsible not only for emergency care, but also for stabilizing patients in the hospital, responding to codes, and supporting hospital-wide emergencies. Allowing off-site supervision weakens an already fragile safety net and removes the most critical layer of protection for patients when resources are limited.

SB 12 moves Kentucky backward at a time when we should be strengthening rural healthcare, not diluting standards of emergency care. If a hospital is open and advertising emergency services, patients deserve the assurance that a physician is present and responsible for their care.

While we recognize the intent of SB 12 to improve access to care across the Commonwealth, we would support the bill only with an amendment that removes the provision allowing off-site supervision of nurse practitioners and physician assistants. Effective supervision in acute and complex clinical environments requires meaningful, readily available physician involvement, not remote or nominal oversight. Allowing off-site supervision risks lowering the standard of care, particularly in emergency and high-acuity settings where timely physician input can be critical to patient outcomes. Maintaining on-site physician supervision ensures patient safety, supports appropriate clinical decision-making, and preserves the team-based model of care that has long served Kentucky patients well.

Please reach out to your legislators and oppose SB12. Every citizen of the Commonwealth deserves to have a physician in the emergency department.

<https://apps.legislature.ky.gov/record/26rs/sb12.html>

Washington, D.C.

President Elect, Ryan Stanton, M.D., had a great time visiting Washington, D.C.

The hit show, The PITT, and the White House! Thank you for your dedication and service to Emergency Medicine.



Measles Outbreaks a Harbinger for ER Docs to Recognize and Promptly Treat

Liz Scherer

January 28, 2026

In 2025, [measles](#) came roaring back in the US, with major outbreaks resulting in more than 2000 confirmed cases reported across the country. Data suggest that 2026 may already be on a trajectory to pass that number; as of January 23, measles has been reported in nine states, with the South Carolina Department of Public Health already declaring an outbreak of more than 700 cases centering on Spartanburg County alone.

Are emergency room (ER) physicians prepared?

Measles holds the title for one of the most virulent infectious diseases. It can remain airborne or on surfaces for up to 2 hours after an infected person leaves a room. If 10 susceptible people who've never been vaccinated or have never had measles previously are exposed, nine will become ill. Left undiagnosed and untreated, it can cause serious complications. The challenge is that many ER doctors have never laid eyes on measles outside of medical textbooks.

“This is something that many emergency clinicians have been trained on in textbooks with pictures that are black and white but really lack the fundamental understanding of how to actually take care of this because they’ve never done it in person,” said Nicholas Cozzi, MD, MBA, emergency medical service medical director and assistant professor of emergency medicine at Rush University Medical Center in Chicago.

“When we’re talking about things that were eliminated, it becomes much more difficult and much more urgent for us to train the next generation of emergency clinicians to take care of patients irrespective of how they present with measles,”

he said. “One of the things we try to do is educate people that measles looks different depending on your skin tone.”



Nicholas Cozzi, MD, MBA

Cozzi noted the number of measles cases has been the highest in decades, which, in combination with ongoing discussions about vaccine schedules and related outcomes, creates “much more of an urgent emphasis for us to be training medical and nursing students how to spot this once eradicated but very rare, serious viral infection.”

Preventing Community Spread

South Carolina’s experience underscores the need for coordinated efforts. Though measles case numbers are currently rising, widespread community exposures started in July, when people started to develop measles symptoms without a clear source, Johnathon Elkes, MD, ER physician and medical director of preparedness for Prisma Health in Greenville, South Carolina, told *Medscape Medical News*.

“That progressed for a couple of months, and over time, those cases built up until we had this rolling snowball downhill, where you have increasing numbers of measles exposures,” he said.

The challenge is to catch these cases early enough to avoid inadvertently exposing other patients or staff.

“If a patient with measles presents to a crowded space or hospital system and is not appropriately quarantined, they could expose many other people in a pretty quick fashion,” Elkes said.

He explained that pediatric practices at Prisma have been especially aggressive in terms of ensuring that they can see patients safely.

“We have a telephone triage line set up so when patients call in with a concern or possible exposure, they can be safely routed to an outpatient facility capable of testing them, which helps avoid exposures in larger public areas,” he said.

Changing Attitudes

In the ER specifically, Prisma policy requires that waiting room patients be masked until they are triaged, undergo screening questions to identify risk, and then immediately isolate them. One important consideration is to ensure enough rooms are available to allow for infection control procedures needed to prevent airborne exposure from a previous patient. With current strains on healthcare systems across the US, this might not always be possible.

Vigilance is key.



Garry Kennebrew, Jr, MD

Garry Kennebrew, Jr, MD, ER physician at The Hospitals of Providence and University Medical Center hospitals in El Paso, Texas, said his haunches have been elevated since last year's significant measles outbreak in the state. Not only was it the largest measles outbreak in decades, resulting in significant hospitalizations and two deaths, but it also spread to bordering states including New Mexico and Oklahoma.

"I've changed my thought process," he said. "At one point in time, I wouldn't necessarily have brought measles to the top of my list. Now, I'm on high alert and make certain, especially with pediatric rashes, that it's not measles."

Aside from including measles in differentials, Kennebrew said that "since the pandemic, I always wear a mask and gloves. That habit has carried over to and fits in well with measles," he said.

Delayed Presentations

Measles presents as a blanching, erythematous, maculopapular rash starting on the face or behind the ears, along with cough and fever. Though it has not necessarily become more severe in recent years, Cozzi said patients are

presenting further in the course of the infection because it's not being spotted consistently.

“More often than not, when a child comes in, it's not the first time they've come to the ER with fever and rash, and that's part of the problem,” said Cozzi. “We have to teach people what this looks like and re-educate ourselves on these infections — not just measles but the infections we once thought were eradicated.”

An important reason for prompt diagnosis is the risk for complications, which can be as great as 40%, especially in children younger than 5 years, adults, and malnourished, pregnant, or [immunocompromised](#) patients. Late manifestations include measles inclusion body [encephalitis](#) and subacute sclerosing panencephalitis ([which remains latent](#) for almost 10 years).

Elkes also raised concerns around testing.

“It's not uncommon for hospital systems to outsource testing and to run samples. That delays turnaround time, which increases the time before you can let someone know of an exposure,” he said. “You also can't let schools know that there has been an exposure, and you may preclude people from being able to receive post-exposure prophylaxis,” Elkes said.

Elkes added that he had never considered the type of social impacts that would occur.

“Multiple times through our current outbreak, we had several middle schools with over 100 children quarantined at home for 21 days,” he said. “We're actually at the point now where some of these schools have had a second exposure. Children who did not get the vaccine and were re-exposed had to do a second period of 21 days of quarantine.”

Across the board, measles recognition, prompt diagnosis, and isolation are critical, especially in the midst of a known community spread. So is slowing down, a trait that can be challenging in the ER setting.

“When there’s 50 people in your waiting room and 35 patients boarding in your ER admitted upstairs but there’s no room for them, it’s easy to see people quickly and try to evaluate and treat them appropriately. But sometimes, when you try to go faster, you can make mistakes,” said Cozzi.

“It’s important to identify someone with the right pattern in terms of the infection and someone who’s at risk because they’re not fully vaccinated. Those are the patients we need to take it a bit slower and more conscientious with,” he said.

Cozzi and Kennebrew reported having no financial disclosures of interest.

Liz Scherer is an independent health and medical journalist with a deep background in infectious diseases.

Credits

Lead image: iStock/Getty Images

Image 1: Rush University Medical Center

Image 2: Harper Kennebrew

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Send comments and news tips to news@medscape.net.

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FROM NATIONAL ACEP



ACEP Resources & Latest News

ACEP Advocacy Win: DEA Issues Long-Awaited EMS "Standing Orders" Final Rule

In a long-awaited victory, the Drug Enforcement Agency (DEA) issued the **Registering Emergency Medical Services Agencies under the Protecting Patient Access to Emergency Medications Act of 2017 Final Rule** to ensure continued access to pain and anti-seizure medications for patients experiencing medical emergencies. [Read more.](#)

Updated ACEP Policy Raises Standard for Emergency Physician-Led Care

On January 27th, the ACEP Board of Directors voted to amend the policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." [Read more.](#)

2026 HHS Funding Update

A bipartisan bill passed by Congress today funds the government through

September 30, 2026. New HHS funding means bipartisan support for ACEP-led efforts. [Read more.](#)

ACEP Will Not Endorse New Sepsis Guidelines from the Surviving Sepsis Campaign

After a thorough and comprehensive review by a panel of experts convened from the membership of the College, the American College of Emergency Physicians (ACEP) today informed the Surviving Sepsis Campaign (SSC) that ACEP will not endorse the organization's latest update to guidelines for treatment of sepsis in emergency departments. [Read more.](#)

NYACEP-Supported Law Strengthens ED Security and Violence Prevention

A new law championed by the New York chapter of ACEP (NYACEP) requires hospitals in the state to establish violence prevention programs. [Read more.](#)

Emergency Departments Should be Safe Zones for Patients

The American College of Emergency Physicians (ACEP) is committed to ensuring that emergency departments remain places where all individuals can safely seek emergency medical care without fear. [Read more.](#)

ACEP Advocacy: Advancing Rural Care, Opposing Non-Competes, Fighting Bad Insurer Behavior

ACEP advocacy keeps delivering key wins for emergency medicine at the federal and state levels. The newest installment of our [members-only Capitol Rounds webinar series](#) keeps you current on advocacy wins, policy changes and important developments in DC and across the country. [Read more.](#)

ACEP to Congress: Stronger Policies, Accountability Can Stop Bad Insurer Behavior

The American College of Emergency Physicians (ACEP) welcomes today's Congressional hearings examining the bad insurer behavior that drives up premiums and increases health care costs for millions of people, limiting access to affordable insurance. [Read more.](#)

ACEP and National Health Care Groups Issue Joint Statement on Pediatric Readiness in Emergency Departments

The lives of more than two thousand children could be saved with new recommendations included in a [joint statement](#) issued by organizations focused on caring for young people in emergencies. [Read more.](#)

ACEP Leads Call for CMS Guidance on Signage to Prevent Violence Against Health Care Workers

The American College of Emergency Physicians (ACEP) and a coalition of health care organizations [sent a letter](#) urging the Centers for Medicare & Medicaid Services (CMS) to issue guidance that facilitates the posting of signage in emergency departments (EDs) discouraging violence. [Read more.](#)

Update on ABEM Physician Portal

ABEM recently transitioned to a new physician portal, MyABEM, and some physicians experienced account access challenges during the transition. [Read more.](#)

Upcoming ACEP Events and Deadlines

- [Talk with Tony](#)
February 12, 2026
6:00 PM – 7:00 PM Central Time
Join ACEP President Dr. Tony Cirillo for his monthly chat with ACEP members. Get the inside scoop on the latest at ACEP and in emergency medicine.

- [Capitol Rounds: The Plot Thickens in DC and Statehouses](#)
February 25, 2026
2:00 PM – 3:00 PM Central Time
Capitol Rounds is back—and the plot is definitely thickening. Join us for a fast, practical rundown of the latest developments important to emergency medicine in Washington, DC, and across statehouses nationwide, including key legislative and regulatory moves, what’s gaining traction, and what to watch next.
- [The Role of HHS in Disaster Response and MASCAL Response and Medicine](#)
March 17, 2026
12:00 PM – 2:00 PM Central Time
Explore key concepts, practical considerations, and real-world applications relevant to emergency medicine, disaster medicine, and prehospital care professionals. Gain insight into current challenges, emerging best practices, and strategies that can be applied across a variety of clinical, operational, and disaster response settings.
- [2026 ACEP Leadership & Advocacy Conference](#)
April 26 – 28, 2026
Washington, District of Columbia
Join your colleagues in Washington, DC, and make your collective voices heard to inspire change for your patients and your specialty.
- [2026 ACEP Scientific Assembly](#)
October 5 – 8, 2026
Chicago, Illinois
The world's largest emergency medicine educational conference bringing together the global EM community. Registration is coming soon!

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