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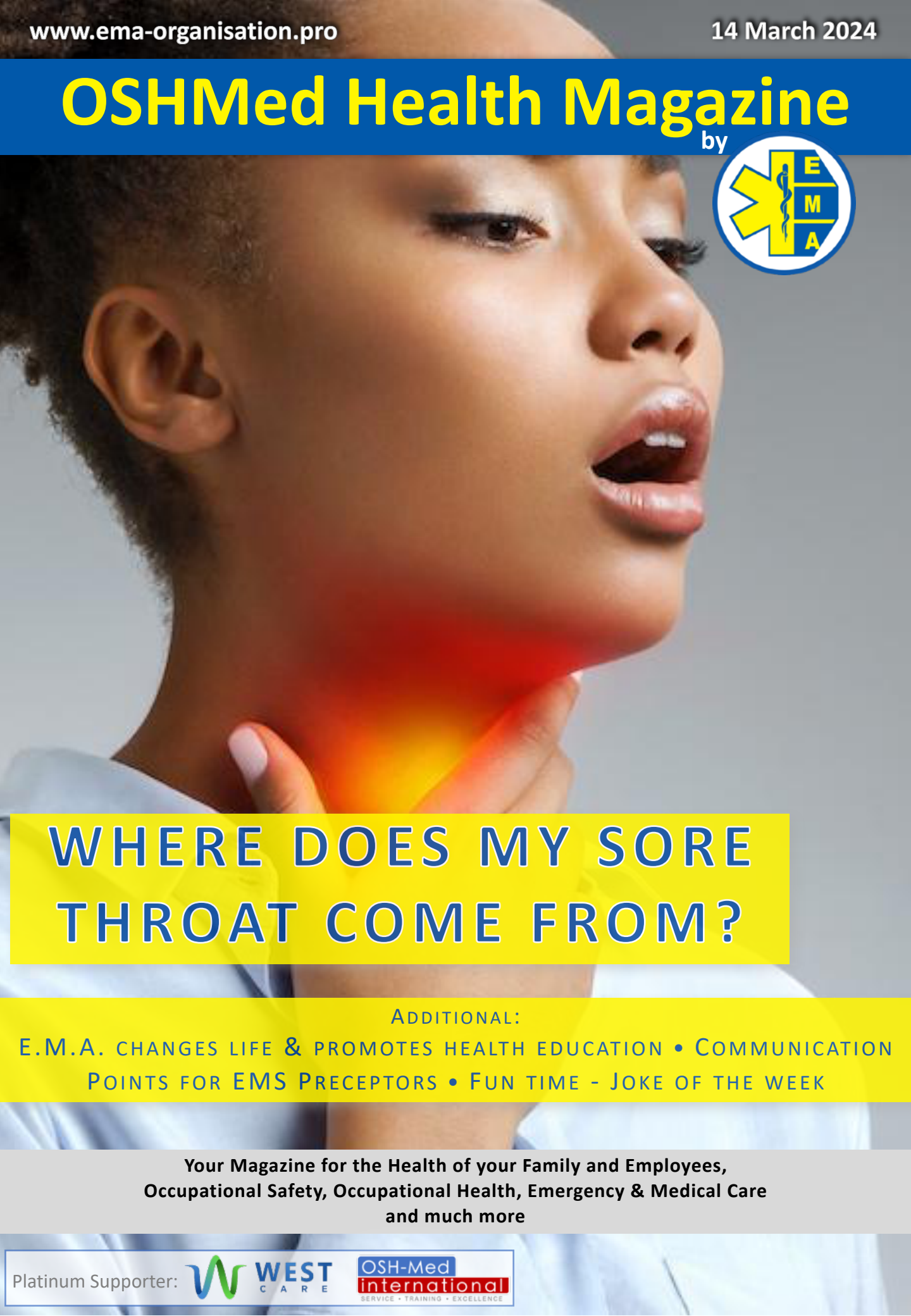
OSHMed Health Magazine

by



WHERE DOES MY SORE THROAT COME FROM?

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On the 09.03.2024, E.M.A. in conjunction with the Ongos Valley Soup Kitchen did a health check of Blood Pressure, Heart Rate and Blood Oxygenation at the Damara Location in Windhoek.

The health check took place from 11h00 to 14h00. It is part of the E.M.A. health campaign to promote health awareness with the focus to fight hypertension and dehydration.
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Where does my sore throat come from?

If your throat hurts, it is often due to a cold or flu. What else causes a sore throat and what gets rid of it?

Briefly summarized

In most cases, a sore throat is the result of viral respiratory infections with sore throats. But they can also have other causes, such as infections with bacteria, irritants or allergies.

If you have a sore throat due to a cold, it helps to drink enough, suck lozenges, take it easy and avoid irritants. If the cause is more serious, your doctor will advise you on how to treat it. Antibiotics are only used for severe bacterial infections.

Actually, everyone knows it: your throat suddenly scratches, you feel weak and you suspect that a cold is coming. In fact, respiratory infections with sore throats are by far the most common cause of sore throats - in children and adults. This also means that a sore throat is mostly harmless. Rarely, they are caused by viruses or bacteria, which can cause serious complications. And sometimes they have other causes such as irritants, heartburn or allergies.

Which infectious diseases cause a sore throat?

Most pathogens that can cause a sore throat are transmitted via smear or droplet infection. With a smear infection, you touch objects contaminated with germs or shake the hands of an infected person and then transfer the pathogens from your own hand to the mucous membranes of the mouth, nose or eyes. In droplet infection, infected people throw pathogen-containing droplets into the air when they sneeze, cough or speak. If you breathe them in, the germs reach the upper respiratory tract, where they multiply quickly. If your own defenses are weakened, the pathogens have an easier time.

Strep throats are usually caused by viruses, but some are also caused by bacteria.

A cold

Cold viruses are the majority of causes of sore throats, for example rhino, adeno, parainfluenza, Coxsackie or RS viruses.

In addition to a sore throat, symptoms of a cold include a runny nose, possibly also fever, cough or headache. Some types of viruses can also cause slightly different symptoms - some can also cause conjunctivitis or mouth ulcers, for

THERE ARE TWO TYPES SORE THROATS

VIRAL INFECTION
(PHARYNGISTIS)

- Most common sore throat, caused by a cold or flu
- Can also be caused by Mononucleosis, measles, chickenpox & croup
- Usually lasts five to seven days and doesn't require medical treatment

BACTERIAL INFECTION
(STREPTOCOCCAL INFECTION)

- A less common type of sore throat caused by bacteria
- Requires treatment with antibiotics to prevent complications
- Usually resolved within treatment time

example. Although the symptoms are annoying, they are usually harmless and go away after a few days.

Pseudocroup

Parainfluenza viruses can also cause pseudocroup, particularly in children, which is typically accompanied by a barking cough - especially at night - and shortness of breath. In very severe cases there is a risk of suffocation.

Pseudocroup attacks can also occur if you have an allergy. They are promoted by air pollutants, for example smoking in the child's environment.

Hand, foot and mouth disease

Coxsackie viruses and others can also cause hand-foot-and-mouth disease, which can, among other things, cause throat problems. Children under the age of ten are usually affected. After the infection, after one or two days of fever, blisters appear in the mouth, which then become small, shallow ulcers (aphthous ulcers). They can be painful and cause the affected child to refuse food. A little later, a non-itchy rash develops, especially on the palms of the hands and soles of the feet. Other regions such as the buttocks can also be affected. The viral illness is usually resolved within ten days.

Flu

Flu is caused by influenza viruses and can have very different symptoms: from mild, cold-like symptoms to severe symptoms with high fever and complications such as pneumonia - in rare cases even fatal in risk groups such as older or immunocompromised people.

The flu often begins with chills and a strong feeling of illness. This can be accompanied by a rapidly rising fever of over 39 degrees Celsius. Sore throat, dry cough, runny nose, nausea, headache, muscle and body aches are also common symptoms. Vomiting and diarrhea may also occur. Some sufferers feel weak and loss of appetite for a long time after recovery. The flu can make you more susceptible to other infections.

Other infections with viruses such as measles (Morbilli) or mumps (goat peter) can also cause a sore throat.

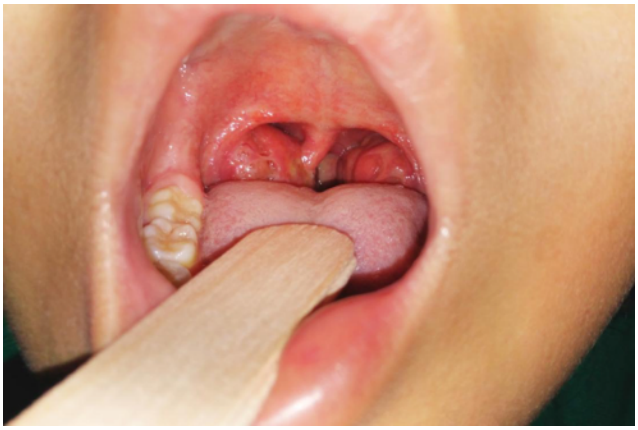
In addition, the herpes simplex virus (HSV-1) can cause unpleasant inflammation of the oral mucosa and throat with painful blisters. There is also fever and swollen lymph nodes in the neck.

The Epstein-Barr virus (EBV) causes Pfeiffer's glandular fever. In the adolescents and young adults who are primarily affected, the clinical picture usually presents as a severe throat infection with pain when swallowing. The acute symptoms are sometimes preceded by a slight fever for days and a drop in performance. The spleen is rarely enlarged and there is a risk of a dangerous rupture of the spleen.

A sore throat and difficulty swallowing can also occur if you are infected with the HIV virus (HIV).

Sore throat caused by bacteria

In addition to viruses, bacteria can also cause an infection in the throat area.



The most common bacterial pathogens that cause sore throats and tonsillitis are streptococci. The main cause of bacterial inflammation of the throat (pharyngitis), angina or both (tonsillopharyngitis) are so-called group A streptococci. According to the Robert Koch Institute, the number of throat infections caused by streptococci in Germany is estimated at one to one and a half million per year[2]. Children between the ages of six and twelve are most commonly affected.

Possible symptoms include a severe sore throat that can radiate to the ears, difficulty swallowing, bad breath, lumpy speech, and swollen lymph nodes in the neck. Headaches, fever, fatigue and, in children, abdominal pain and vomiting are also common. Sometimes the symptoms of the disease are only mild.

But other bacteria such as staphylococci or pneumococci can also cause bacterial sore throats, and very rarely gonorrhea or syphilis bacteria.

When a sinus infection (rhinosinusitis) occurs, inflammatory secretions sometimes flow down the back of the throat. This can cause constant throat clearing, hoarseness, sore throats and coughing.

Other bacterial infections that can cause a sore throat include:

Scarlet fever (caused by streptococcal A bacteria)
Diphtheria (caused by Corynebacterium diphtheriae)
Haemophilus influenzae: Children are now vaccinated against bacteria of the type Haemophilus influenzae b (Hib). In earlier times, the pathogen more often led to, among other things, the dangerous epiglottis (epiglottitis) in small children.
What other causes are there?
Irritants: Tobacco smoke in particular, but also other chemicals and dusts, can irritate the mucous membrane in the throat and cause a sore throat.

Dry room air: Dry air can cause problems for the throat, especially during the heating season. If you breathe a lot through your open mouth, especially when you sleep, for example when you have a cold, hay fever or snoring, you can get a dry and sore throat.

Allergies: It's not just allergies that are triggered by flying allergens such as pollen, house dust or mold components that can cause a sore throat. They can also occur with food allergies. It's more like a painful itch in the throat.

Speaking a lot or loudly: Excessive use of the voice can also cause a sore throat and hoarseness. The vocal cords then need a few days of rest to recover. This means: Don't speak loudly and especially don't shout. Whispering is also not recommended as it also strains the voice.

Reflux disease (heartburn): Reflux disease is generally underestimated as a cause of sore throats, but is also a possible cause. Acid stomach contents flow from the digestive tract up into the esophagus, especially at night. Depending on the extent, the esophagus becomes irritated and inflamed. Typical symptoms include heartburn, belching, difficulty swallowing, hoarseness and a feeling of a lump in the throat, and sometimes a dry cough.

Chemotherapy or radiation therapy: Chemotherapy or radiation therapy in the head and neck area often leads to a temporary, painful inflammation of the mucous membranes in the mouth (oral mucositis) and throat. This can make eating temporarily difficult. The treatment team advises those affected in a timely manner on how best to cope.

Malignant tumors in the mouth, throat, larynx and esophagus. Pain usually only occurs as these diseases progress. Smoking and alcohol consumption are risk factors for numerous cancers.

Immune reaction against medications: In rare cases, some medications can trigger a pathological immune reaction in which the number of white blood cells that are important for defending against disease decreases. Infections can then develop, which can cause symptoms such as sore throat, fever and painful mucous membrane changes and can lead to blood poisoning (sepsis). If you suspect such a reaction, you should consult your doctor.

What types of sore throats are there?

When an infection occurs, the mucous membrane in the throat becomes inflamed. Depending on where exactly the inflammation occurs, there is inflammation of the throat (pharyngitis), tonsillitis (angina tonsillaris, tonsillitis), or inflammation of the larynx (laryngitis). When tonsillitis occurs, the tonsils are particularly affected. The lateral angina affects the lateral lymphatics in the throat wall. Inflammation of the epiglottis (epiglottitis) also occurs rarely. It used to occur mainly in children between the ages of two and eight. Vaccination against the most common trigger, the germ Haemophilus influenzae b (Hib), has pushed back the dreaded disease.

Sore throats occur acutely, recurrently (recurrently) and chronically. They are considered acute if they have existed for a maximum of two weeks. But they usually subside after a week. One or both sides of the neck may be affected.

Sore throat: When to see a doctor?

A sore throat caused by a cold usually goes away within a week. However, if there are indications of a more severe course, you should seek medical advice immediately.

This applies, for example, to the following accompanying symptoms:

- Marked feeling of illness or weakness
- Chest pain
- Fever that lasts longer than three days, a high fever, or a fever that increases again after a few days
- Severe, increasing or recurring sore throat or if there is no improvement after three to four days
- Violent cough
- Sensation of lump in throat
- Increasing or recurring difficulty swallowing
- Shortness of breath, pulling, wheezing, blue lips - if there is significant shortness of breath it is an emergency. Alert the emergency services immediately on 9112!
- chills
- Difficulty opening your mouth (jaw lock)

- Mouth ulcers, bad breath
- skin rash
- Enlarged, painful lymph nodes on the neck or neck
- Lightheadedness

Abnormalities such as fever, chills, mouth and throat pain associated with medication treatment

Attention: If an infant has a fever of 38 degrees Celsius or more or a child has a fever of 39 degrees Celsius or more, they should be examined by a doctor. Likewise if you have a low fever that lasts for more than three days.

What helps with a sore throat?

It helps with a sore throat

drink enough and keep the mucous membrane well moist. This helps the sore throat defend itself against pathogens.

to take it easy for a while.

Avoid irritants and not smoke.

To suck lozenges. They often contain extracts from sage, ribwort plantain or Icelandic moss. The plant substances found in sage or thyme, for example, have a pain-relieving effect. Likewise, increased salivation when sucking. Often also helpful: lozenges with a local anesthetic or mild painkillers.

In addition, certain home remedies may be able to help with uncomplicated sore throats:

Neck wraps: Many people swear by cooling neck wraps for a sore throat or tonsillitis. They dissipate heat and can therefore have a decongestant effect. To do this, place a cloth or compress soaked in lukewarm water (but not dripping wet) on your neck, then wrap a dry cloth and a woolen cloth over it. Leave on for about fifteen minutes. You can reapply the wrap several times.

Teas, gargling: Cold teas with linden blossoms and elderflowers are often recommended for dry, irritating coughs and a sore throat. They help to moisten and protect the mucous membranes in the respiratory tract. Sage tea or salt water, for example, are suitable for gargling. To do this, dissolve about a teaspoon of salt in a glass of water.

It is best to seek advice from the pharmacy. You should always only use home remedies temporarily. If the symptoms do not improve within a short time, go to the doctor.

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Driving Tips While Driving in the Rain
Allow for more time
Brake earlier
Turn on headlights

Communication Points for EMS Preceptors

In our daily life, communication helps us build relationships by allowing us to share our experiences, and needs, and helps us connect to others. It's the essence of life, allowing us to express feelings, pass on information and share thoughts. We all need to communicate.

Communication is foundational to the clinical experience. How we communicate our assessment findings to our partner or the receiving facility, how we communicate between the first responder on the scene and the ambulance team who will assume care, and most importantly how the preceptor communicates with his student, is at the core of ensuring good patient care. Navigating the intricate dynamics of the EMS clinical educational environment necessitates a thoughtful approach to setting expectations, especially before a student's first assignment.

The initiation of this working relationship sets the tone for the subsequent pedagogical interactions and professional development. Explicitly outlining how patient encounters should be conducted serves not only as a pedagogical tool but also as a framework for evaluation and feedback. The preceptor can assess the student's reasoning skills by requiring the student to complete an assessment first, then explain their diagnostic findings and proposed treatment algorithm. This process provides a structured learning experience that allows for tailored instruction and minimizes misunderstandings.

In EMS education, the stakes are high; the actions taken—or not taken—have immediate real-world implications. Mastering the skill of assessment is particularly crucial, as it underpins the art and science of paramedicine. It is one thing to teach someone how to perform a procedure, but another entirely to instill the clinical judgment required to discern when that procedure is necessary. A preceptor's guidance evolves as the student gains competence, gradually shifting from a directive role to a more collaborative partnership. By acknowledging that the teaching-learning relationship is bidirectional, both preceptor and student can align their expectations, identify challenges early, and establish a rapport that fosters authentic learning and professional growth.

Discuss Expectations Before the First Assignment

It is important to understand expectations before the first assignment. If you have a new student/intern, you may want to outline how you want to see a patient's progress. For the author, he would let his students know that he wanted to see them complete the assessment first. Explain what they found, and then what treatment algorithm they were going to institute. This allows the preceptor a chance to understand how a student arrived at a particular choice. As time progresses, and you know the student understands what they need to perform, you will probably tell the student this isn't necessary.

Figuring out what is wrong with our patients and what we need to do to treat them, the assessment is the hardest part of what we do. We can find anyone off the street and teach them how to start an IV, give an injection, or insert a supraglottic airway. The hard part is knowing WHEN to use those devices, or what you need to do to resuscitate a patient.

As your student demonstrates greater ability, you may develop a more fluid progression, more akin to a typical 'partner' relationship, where the student could concentrate more on infrequent skills or assessment techniques. For example, if you encountered a patient who needed to receive transcutaneous pacing, you might start the IV line and sedate the patient while your student placed the pads and performed other key tasks, leading up to actual pacing if this was a skill or process they have not had a chance to perform.

At the same time find out what the

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student needs from you. What do they expect or want from you, the preceptor? What are the challenges they are experiencing, and what are the skills that they have trepidation over? This allows the preceptor to work through and identify problems before they occur. More importantly, the preceptor can help the student develop a method or approach to address that issue ahead of time, rather than have it come up in the middle of an assignment. The student may not recognize all of their shortcomings, so there may be calls where they require help on the fly, but they have established a relationship of trust with their preceptor. Here true learning can occur.

The author has had students say (literally) “I am just here to start IVs, push meds, and drop tubes”. While that may be their perception, nothing is further from the truth. The clinical development from student to paramedic is robust, and dynamic, and includes many skills beyond IVs, meds, and ‘tubes’.

Signals

The author worked in a high-volume EMS system, where there was tremendous potential for violence. One signal the author had for his partner and everyone else in the room was to say they needed a hand getting the Reeves stretcher. The Reeves stretcher could easily be carried upstairs by one person, but by asking for help to carry the stretcher, and implying that it required two people, it was a tacit signal that there was a danger that could not be announced and allowed the crew to leave without rousing suspicion or ire.

Another signal the author would use was to say out loud ‘Let me place the portable oxygen over here for a moment’. He would then place it next to the potential danger or person of concern. Once he did this to alert everyone to the presence of a firearm on a nightstand.

Another signal used is between the preceptor and the student. If the student needed help or the preceptor needed to intervene, having a signal that allowed for this transition to take place without causing undue scrutiny or alarm to the family or the patient was essential. These phrases should be innocuous. Some examples include:

1. "Would you mind double-checking this (medication dosage, IV, tube, etc.) for me?"
2. "Can I get your opinion on this?"
3. "I think this might be a good teaching moment." (Used by student or preceptor)
4. "Let me help you with that (assessment, treatment, etc.)"

5. "Would you mind going over this (ECG, ETI placement, IO access, etc.) with me?"

These phrases sound professional and routine, allowing for the preceptor to step in seamlessly or the student who is facing a challenge the opportunity to seamlessly transition care without causing concern for the patient. This approach respects the need for effective, discreet communication in a clinical setting while respecting the student, the patient, their family, and the preceptor.

Review and Reflection

The post-mortem assessment of an EMS assignment is critical to the learning process. This happens twice, immediately after a call, and later on after the patient is admitted or discharged, and there is a chance to obtain the diagnosis. Sometimes what we feel in the moment, is that the patient needs to be a stroke alert for example, we may only find out later that the patient had a metabolic issue – in this instance, this is a learning moment not only for the student but also for the preceptor.

That immediate post-call review allows for an opportunity to improve performance. You should tell the student immediately what they did correctly. Don't perform a feedback sandwich, the student will turn you off but do tell them what they did correctly, and be specific. Never just say 'Good call kid', but provide them something specific about what they did about their assessment or treatment that was notable.

You should only correct them if they need it. If the call went well you may not need to say anything about what could have been done better. If there is something that needs to be discussed, then, before you launch into what they may have done wrong, ask them to summarize the call. At this point bring up salient points they may have missed, if they missed any (they may not have). Then ask the student what they could have done better. Don't ask them, 'what did you do wrong.' This places the student on the defensive. Instead, ask them what would they do better, but more importantly ask why they would make that change. It is during this reflective period that you will find most students are aware of what they did and what they need to do to improve. If they don't, in a positive tone, point out what could have been performed better, and

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Summary

The art of effective preceptorship in the EMS educational sphere is far more nuanced than mere didactic instruction; it encompasses an intricate blend of communication, trust, and adaptability. The development and use of pre-established signals and communication points not only serve as mechanisms for real-time feedback but also establish an environment conducive to nuanced understanding and mutual respect. This nuanced dialogue allows the preceptor and student to not only respond effectively to immediate clinical needs but also to anticipate future challenges. It evolves from the foundation of clear expectations set forth at the beginning of the educational journey, becoming an integral part of a dynamic educational feedback loop.

As EMS professionals tasked with critical on-the-spot decision-making, the role of the preceptor extends far beyond that of a traditional educator. They serve as gatekeepers to the professional norms, clinical judgment, and ethical considerations that are fundamental to the field of EMS. Equipped with pedagogical tools tailored to facilitate progressive learning—from setting initial expectations to post-event reflective assessments—the preceptor can guide the student in mastering the complex skills and judgment required in emergency settings. The success of this educational enterprise is gauged not merely by the technical proficiency a student gains but by their ability to integrate these skills seamlessly into a comprehensive approach to patient care. Thus, a thoughtfully implemented preceptorship contributes to the development of proficient practitioners and the evolution of a field continually striving for excellence.

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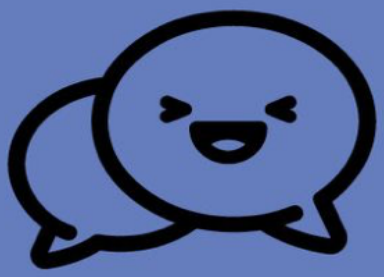
Fun Time - *Joke of the week*



What did the left eye say to the right eye?

Between us, something smells.

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- **How many** injured person
- **Waiting** for further question

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