

Web 2.0

Objective: *Formulate a plan for optimization and consolidation of our current online interactive resources and determine if utilization of initial resources would be useful.*

Background: *Web 2.0 can be defined as online applications that are user centered and designed to foster interactivity, collaboration and information sharing. Examples include social media such as Facebook and Twitter, wikis, blogs and podcasts. In the past several years we have begun to utilize many of these applications and our residency now has presence on Facebook, Twitter and in several wikis. Blogs being scraped into our Facebook fanpage include: EMRes by Bjorn Peterson, EM Shorts by Stephanie Taft, EMS Perspective by Aaron Burnett, Twin Cities Toxicology by Sam Stellpflug, Regions TraumaPro by Mike McGonigal, and Dr. Smith's ECG Blog by Steve Smith at HCMC. Currently there are many resources in use, however accessing them can be challenging as there is not a consolidated home for them at this time.*

Idea Generation:

Plan for Progress:
(include task leaders, objectives and timeline)



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Regions Hospital Emergency Medicine Residency



ED Thoracotomy Part 3: Clamping The Aorta Finally, the chest is...

Debakey clamp Anatomy ED Thoracotomy Part 3: Clamping The Aorta Finally, the chest is open and the tamponade has been relieved. But your patient has little volume. In order to conserve any circulating blood and pump it only to the heart and the head, it's time to cross clamp the aorta....

Source: [RegionsTraumaPro.com](#) - Dr. Michael McGonigal

Published: 2011-10-21 14:00:05 GMT


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Regions Hospital Emergency Medicine Residency

Posterior CVA — October 20, 2011

Critical Case Conference — Discussion by Dr. Keith Henry and Dr. Michael Rosenbloom (staff HP Neurologist) Acute CVA 10 minutes — MD eval (determine at this point if pt is a candidate for thrombolytics) 45 minutes — work up completed ... Continue reading →

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Posterior CVA — October 20, 2011

Critical Case Conference — Discussion by Dr. Keith Henry and Dr. Michael Rosenbloom (staff HP Neurologist) Acute CVA 10 minutes — MD eval (determine at this point if pt is a candidate for thrombolytics) 45 minutes — work up completed (CT with results, ECG, CXR) 60 minutes — door to needle time (time to administer lytics) Consider stroke mimics (hypoglycemia, seizure; Complex migraine — may look like CVA so lytics may be administered....



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Posterior CVA — October 20, 2011

by STEPHANIE TAFT, MD on OCTOBER 20, 2011 · [LEAVE A COMMENT](#)

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Supraglottitis

on OCTOBER 13, 2011 by STEPHANIE
TAFT, MD

Critical Case — Discussion by Stephanie Taft, MD Adult “epiglottitis” really can involve all supraglottic structures; epiglottitis itself may be normal Epiglottic involvement usually shows up as an abscess Staph and strep most commonly cultured from abscesses H. flu is ...
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Minnesota Tube Placement

on OCTOBER 6, 2011 by ADMIN

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Pediatric Stroke

on OCTOBER 6, 2011 by STEPHANIE TAFT,
MD

Pediatric Stroke — Discussion by Dr. Felix Ankel and Dr. Timothy Feyma Incidence: 2-63/100,000 children per year in the US — 3000 kids/year vs 700,000 adults ED Work up: CT/MR, CBC, Coags, ESR, CRP.

Iron Toxicity

on OCTOBER 5, 2011 by SONALI

Iron Toxicity Iron is a commonly prescribed substance and is, therefore, still a common ingestion, especially in childhood. Toxic Doses (approximate) 20-30 mg/kg -> self-limited vomiting, abdominal pain, diarrhea >40 mg/kg -> potentially serious

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OTHER RESOURCES

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[The Prehospital Perspective](#)

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[Twin Cities Toxicology](#)

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emshorts*Just another WordPress.com site*

Posterior CVA — October 20, 2011Posted on [October 20, 2011](#) by [Stephanie Taft, MD](#)

Critical Case Conference — Discussion by Dr. Keith Henry and Dr. Michael Rosenbloom (staff HP Neurologist)

Acute CVA

10 minutes — MD eval (determine at this point if pt is a candidate for thrombolytics)

45 minutes — work up completed (CT with results, ECG, CXR)

60 minutes — door to needle time (time to administer lytics)

Consider stroke mimics (hypoglycemia, seizure; Complex migraine — may look like CVA so lytics may be administered. The good news: unlikely to bleed because hemorrhagic conversion usually occurs because of damaged/infarcted tissue)

Examine patient: Attempt to localize anatomic lesion

Establish time of onset

NIH Stroke Scale

Posterior stroke symptoms — dizziness, diplopia, dysarthria, dysphagia, dystaxia, “drop attacks”

Head CT not as good as MRI for examination of posterior fossa. Must be suspicious by symptoms and clinical presentation. There are certain sequences that are routinely done with MR that are very sensitive for blood (i.e. MR may be the better test overall).

Vertebral artery/basilar thrombus with large area of cerebellar infarction — serious risk of hemorrhagic conversion with lytics or heparin which can lead to bleeding in small confined posterior space, leading to herniation and death — high risk to give lytics.

Expressive aphasia — cortical phenomenon — vast majority of time, the speech center is in left hemisphere even in left-handed people

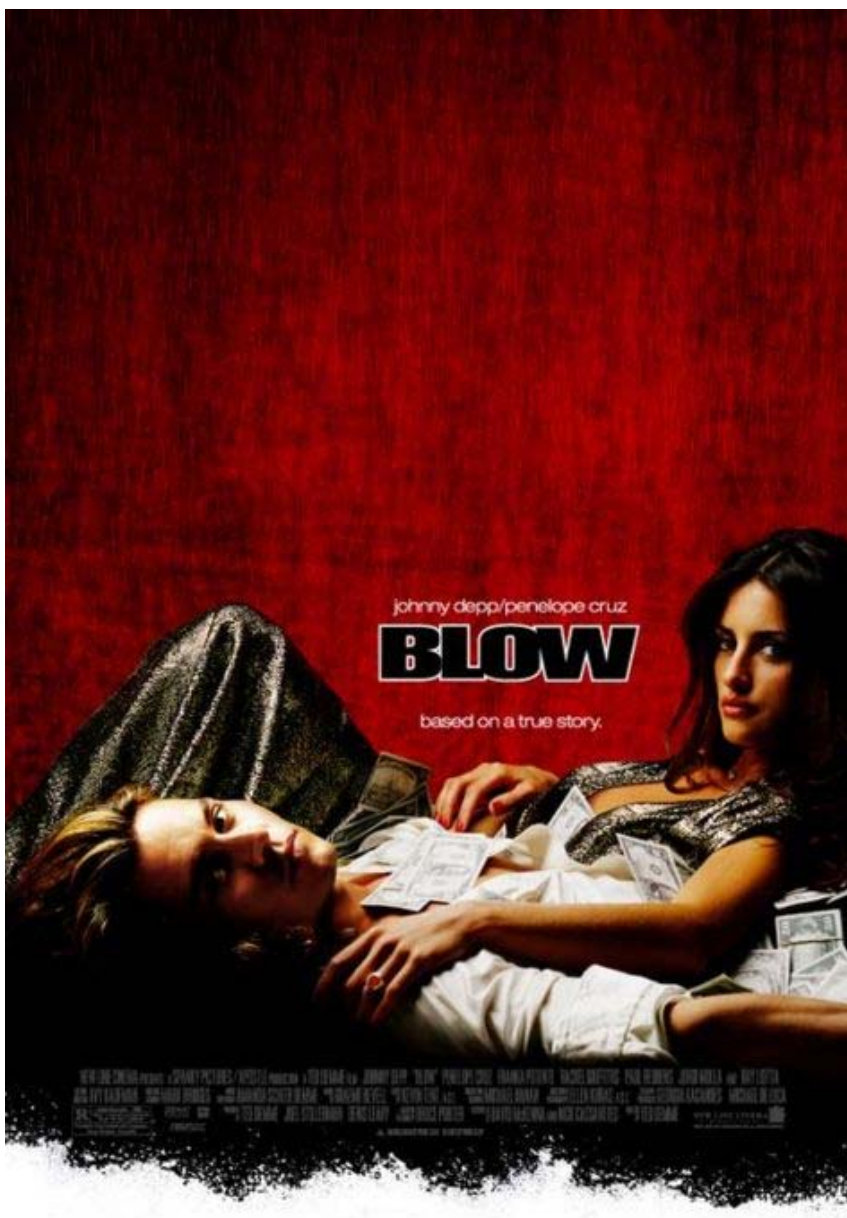
Dysarthria — lack of coordination of speech, muscular inability to form words, usually associated with dysphagia, usually a brainstem lesion

“Top of the basilar syndrome” — thromboembolic occlusion of top of basilar artery — flick off clot to other areas of brain, can result in “locked-in” syndrome, bilateral thalamic ischemia, manifest with visual and oculomotor deficits, behavioral abnormalities, somnolence, hallucinations, dream-like behavior, motor dysfunction often absent (radiopaedia.org, accessed on 10/20/2011)

Posted in [Neurology](#), [Uncategorized](#) | [Leave a comment](#)

SupraglottitisPosted on [October 13, 2011](#) by [Stephanie Taft, MD](#)

Twin Cities Toxicology



Samuel J Stellpflug, MD
Asst Dir, Regions Hospital
Toxicology
Senior Staff, Regions Hospital EM
Dept
Asst Prof, U of M Dept of EM
Toxicologist Consultant, Hennepin
Regional Poison Center (HRPC)

Carson R Harris, MD
Dir, Regions Hospital Toxicology
Senior Staff, Regions Hospital EM
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Toxicologist Consultant, HRPC

Kristin M Engebretsen, PharmD,
DABAT
Toxicologist, Regions Hospital Tox
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Jon B Cole, MD
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Faculty Emergency Physician, HCMC
Asst Prof, U of M Dept of EM

Heather Ellsworth, MD
Senior Fellow, Twin Cities Tox
EM Physician

Benjamin S Orozco, MD
Junior Fellow, Twin Cities Tox
EM Physician

Andrew Topliff, MD
Toxicology Fellowship Director
Asst Poison Center Director, HRPC

Links:

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Clinical Service Website: [Regions Tox](#)
([google site](#))

Hennepin Regional Poison Center:
<http://www.mnpoison.org/>

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Regions EMS

Announcing our EMS Fellow for 2012: Dr. Bjorn Peterson

Regions EMS is proud to announce that Dr. Bjorn Peterson has been accepted as our Prehospital Medicine/EMS Fellow starting summer 2012! Dr. Peterson is currently a chief resident in Emergency Medicine at Regions Hospital. During his residency he completed our resident Associate Medical Director program with Maplewood Fire/EMS where he spent a significant amount of time in the field. Dr. Peterson received his undergraduate degree in computer science from Bethel University in Arden Hills, MN....

 Source: [The Prehospital Perspective](#)

Published: 2011-10-18 13:09:37 GMT



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[Aaron Browne](#), [Felix Ankel](#) and [Regions EMS](#) like this.

Jeremy Coudron Congratulations Dr Peterson
Wednesday at 2:14am

Regions EMS

The State of the Science: ACD-CPR

The emerging science behind cardiopulmonary resuscitation and emergency cardiovascular care has been advancing at a rapid pace. One of the biggest developments is the rise of Active Compression-Decompression CPR. Understanding the fundamental concepts behind this new technique will help EMS providers implement it in the field! One of the most fundamental changes in our understanding of the physiology of CPR stems from the way we now understand the pressure changes in the thorax that take place during compressions and...

 Source: [The Prehospital Perspective](#)

Published: 2011-10-16 01:13:36 GMT

The Prehospital Perspective

*This site provides educational resources
for EMS professionals*

Announcing our EMS Fellow for 2012: Dr. Bjorn Peterson

Posted on October 18, 2011 by Regions EMS Physician



Regions EMS is proud to announce that Dr. Bjorn Peterson has been accepted as our Prehospital Medicine/EMS Fellow starting summer 2012! Dr. Peterson is currently a chief resident in Emergency Medicine at Regions Hospital. During his residency he completed our resident Associate Medical Director program with Maplewood Fire/EMS where he spent a significant amount of time in the field.

Dr. Peterson received his undergraduate degree in computer science from Bethel University in Arden Hills, MN. He earned his medical degree from Loma Linda University School of Medicine where he was elected to the prestigious Alpha Omega Alpha medical honor society. He has experience as an Emergency Room Technician and EMT-B. We are very excited to have Dr. Peterson join our team and we look forward to the valuable contributions we are sure he will make to the field of prehospital medicine!

Regions Hospital EMS has been hosting a [Prehospital Medicine/EMS fellowship](#) since 2010. In [September of 2010 the American Board of Emergency Medicine](#) announced that Prehospital Medicine/EMS was selected by the American Board of Medical Specialties as the newest subspecialty to be awarded board certification.

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The State of the Science: ACD-CPR

Posted on October 16, 2011 by Regions EMS Physician



The emerging science behind cardiopulmonary resuscitation and emergency cardiovascular care has been advancing at a rapid pace. One of the biggest developments is the rise of Active Compression-Decompression CPR. Understanding the fundamental concepts behind this new technique will help EMS providers implement it in the field!

One of the most fundamental changes in our understanding of the physiology of CPR stems from the way we now understand the pressure changes in the thorax that take place during compressions and ventilations (the thoracic pump theory). When a rescuer presses down during a chest compression the pressure in the thoracic cavity is increased. Blood moves

forward and air is forced out of the lungs. For years compression of the chest was our sole focus of CPR. What has changed is how we view the pressure inside the thorax as the chest wall recoils during the decompression phase of CPR. As the downward pressure from the compression is released, the chest recoils



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Doctor · Saint Paul, Minnesota

WallRegions Hospital Trauma P... · [Everyone \(Top Posts\)](#)**Share:**[Post](#)[Photo](#)**Regions Hospital Trauma Programs** created an event.**TCAA Trauma PI Course**Tuesday, November 1, 2011 at 5:00pm
San Diego, CA[Like](#) · [Comment](#) · September 28 at 10:07am**Regions Hospital Trauma Programs**See if you can figure out what is going on in the trauma xray!! <http://bit.ly/7VeLFW>**The Trauma Professional's Blog**

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The Trauma Professional's Blog provides information on injury-related topics to trauma professionals. It is written by Michael McGonigal MD, the Director of Trauma Services at Regions Hospital in St....

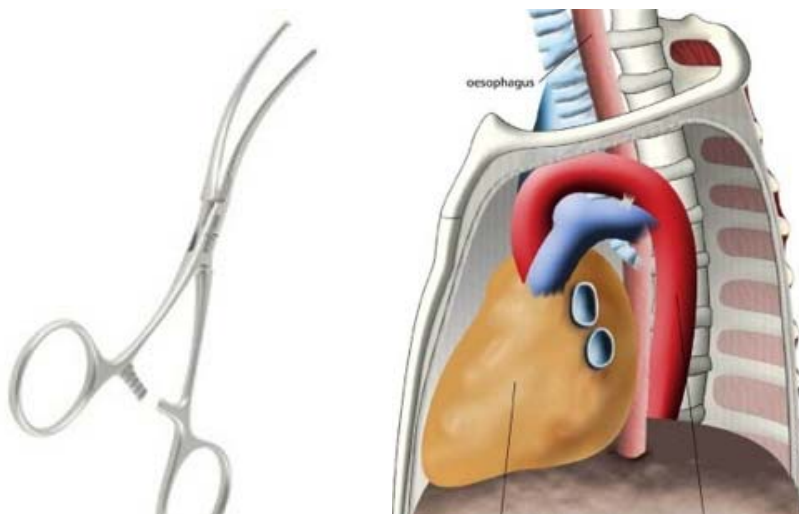
[Like](#) · [Comment](#) · September 21 at 5:15pm**RECENT ACTIVITY**Regions Hospital Trauma Programs edited their [Phone](#), [Website](#) and [About](#).**Regions Hospital Trauma Programs**When to image the aorta after blunt trauma. <http://bit.ly/7VeLFW>**The Trauma Professional's Blog**

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The Trauma Professional's Blog provides information on injury-related topics to trauma professionals. It is written by Michael McGonigal MD, the Director of Trauma Services at Regions Hospital in St....

[Like](#) · [Comment](#) · September 20 at 2:52pm**Regions Hospital Trauma Programs**

The Trauma Professional's Blog



The Trauma Professional's Blog provides information on injury-related topics to trauma professionals. It is written by Michael McGonigal MD, the Director of Trauma Services at Regions Hospital in St. Paul, MN. Regions is a Level I Adult Trauma Center, and has partnered with Gillette Children's Specialty Hospital to become the first Level I Pediatric Trauma Center in the Upper Midwest.

Want to see a post on a specific topic? [Click here or go to www.regionstraumapro.com/ask](#). You can also email me at Michael.D.McGonigal@HealthPartners.com

To view the *Terms of Service* for this site, [click here](#).

ED Thoracotomy Part 3: Clamping The Aorta

Finally, the chest is open and the tamponade has been relieved. But your patient has little volume. In order to conserve any circulating blood and pump it only to the heart and the head, it's time to cross clamp the aorta. **This task is best left to the surgeon, because it is not a simple matter.**

First, you have to locate the aorta, ideally somewhere just above the diaphragm. Unfortunately, if the patient is hypovolemic it's very difficult to distinguish the aorta from the esophagus, which lie right next to each other (see picture above). In order to make them feel different, **insert a gastric tube through the mouth or nose.**

Next, separate the aorta and esophagus. They are both covered by pleura. The structure nearest you without the tube in it will be the aorta. Sometimes it's possible to use a finger to dissect through the pleura and around the aorta. However, the younger the patient, the tougher this tissue is. It may be necessary to incise the pleura with scissors while your assistant holds the lung anteriorly, our of the way.

Finally, once you can pass a finger completely around the aorta, use it to guide the placement of a gently curved DeBakey type clamp (see picture on the left). Squeeze it until it clicks once, and you are done! Now rapidly infuse warmed blood into the patient and run to the OR!

Related posts:

- [ED thoracotomy practice guideline](#)
- [Part 1: getting in](#)
- [Part 2: the heart](#)
- [Foley catheter plugging a hole in the heart](#)

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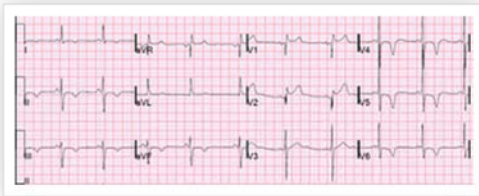
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Wednesday, October 12, 2011

ST elevation (Saddleback), is it STEMI?

This 56 year old male presented with atypical chest pain and left arm numbness off and on for one week, worse on the day of presentation:



There is saddleback type ST elevation in leads V2 and V3, and diffuse T-wave inversion. But there is also very high voltage especially in V4 (35mm, sorry it is cut off) and V5 (27 mm). The QTC was 426 ms.

Answer is below:

This ECG was shown to me by a colleague, and I immediately said: "You thought it was a STEMI, but it is not." He had, in fact, activated the cath lab, and the coronaries were clean and the patient ruled out.

Saddleback ST elevation, in my experience, is rarely due to STEMI. I will not say it is never due to STEMI because I know of no research on this topic. It is usually a form of early repolarization that also usually meets criteria for type II or III Brugada pattern. I will post more on this topic later. In this case, it may be related to the LVH or be simultaneous early repolarization and LVH. The diffuse (both inferior and precordial) T-wave inversion is somewhat atypical of LVH.

Echocardiography confirmed marked concentric LVH.

In this case, you might want to try applying the early repol/anterior STEMI equation rule posted on the sidebar. However, it is not validated in the presence of LVH. You would get a value of 16.11, which is very low and argues strongly against LAD occlusion.

Posted by Steve Smith at 10:58 AM 6 comments [Links to this post](#)

Recommend this on Google

Labels: [early repolarization](#), [false positive cath lab activation](#), [LVH](#), [saddleback STE](#)

Reactions: [interesting \(3\)](#) [helpful \(2\)](#)

**Search This Blog**
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about Dr. Smith

Dr. Stephen W. Smith is a faculty physician in the [Emergency Department at Hennepin County Medical Center in Minneapolis, MN](#), and an Associate Professor of Emergency Medicine at the [University of Minnesota](#).

Comments not appropriate for general posting, or interesting ECGs, may be sent here (do this judiciously!): dr.smiths.ecg.blog@gmail.com.

I highly recommend using this blog as an atlas or textbook. Use the "label" below the archive (below) to search for all kinds of ECG cases, with discussion.

Here is the equation for differentiating the ST elevation of early repol from that of LAD occlusion:

$$(1.196 \times \text{STE at 60 ms after the J-point in V3 in mm}) + (0.059 \times \text{computerized QTc}) - (0.326 \times \text{R-wave Amplitude in V4 in mm})$$

A value greater than 23.4 is quite sensitive and specific for LAD occlusion.

Video Lectures of Dr. Smith

View Dr. Smith's lectures on Acute Coronary Syndromes on hqmeded.com. [ACS 1](#) is on Unstable Angina and NSTEMI. [ACS 2](#) is on STEMI. Each is one hour.

Here is a new lecture on [narrow complex tachycardia](#). And another new one on [wide complex tachycardia](#).

The blog is featured on Podcast 42 of [EMCrit](#), with an interview on various aspects of the ECG in MI, and another [EMCrit feature](#) on left bundle branch block, with an interview.

All ad revenues go to Minneapolis Medical Research Foundation.

Follow on Twitter: www.twitter.com/smithECGBlog

Links

Critical Decisions in Acute Care electrocardiography -- ACS section by Dr. Smith

Dr. Smith's book (Amazon) (now out of print and out of stock; some used copies available, hoping to publish it electronically)

hqmeded.com

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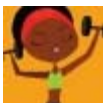
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The NEJM offers a great synopsis of #GME funding at the federal level. #meded
<http://ow.ly/6WNcg>

The Uncertain Future of Medicare and Graduate Medical Education — NEJM

ow.ly

Health Policy Report from The New England Journal of Medicine — The
 Uncertain Future of Medicare and Graduate Medical Education



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HealthPartners Institute for Medical Education

The University of Minnesota launched a bed bug website and hotline yesterday...you can reference our June Pearl of Knowledge on this topic for more information as well. <http://www.healthpartners.com/ime/learning-resources/pearls-of-knowledge/index.html>

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Amy Rosemark Murphy and Cancer Center of Western Wisconsin like this.



HealthPartners Institute for Medical Education

Congrats to our clinical simulation team for completing their SSH accreditation site visit!! <http://ow.ly/6SCdx>



Society for Simulation in Healthcare

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Amy Rosemark Murphy likes this.



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OCTOBER 24, 2011

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Web 2.0 For Emergency Physicians

July 7, 2009 By [Chris Nickson](#) [2 Comments](#)

Last updated 20 October 2011

What Is Web 2.0 For Emergency Physicians?

Even though “[the times they are a changing](#)”, many Emergency Physicians are unfamiliar with the concept of **Web 2.0**, the diversity of Web 2.0 resources, and how to use these resources to enhance their clinical practice and professional development.

This guide addresses these issues so that Emergency Physicians won't be afraid to take a ride on the ‘**Web 2.0 roller coaster**’! (You might like to brush up on some [Basic Web Definitions](#) as well).

What Is Web 2.0?

Web 2.0 is a nebulous term referring to the **current era** of web development and design that, according to [Wikipedia](#), is characterized by **information sharing, collaboration, and interoperability**. Web 2.0 changes the way we access, store, and receive information. The Web, rather than the desktop computer, has become **the platform that matters**. Web 2.0 resources provide us with **boundless** information that is:

Rapidly **accessible** anytime, from anywhere with an internet connection

Current and continuously **updated**

Dynamic and **interactive**

Created **collaboratively**

Easily **stored, shared, and modified**

Many of us are using Web 2.0 in our everyday lives already. Have you ever read a blog (that would have to be a yes...), or used a popular website such as [Wikipedia](#), [Facebook](#), [Youtube](#) or [Flickr](#), or do you have a Google account? Then you have used a Web 2.0 resource.

Web 2.0 in under 5 minutes -- ‘The Machine is Us/ing Us’ by Michael Wesch:

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How Does Web 2.0 Compare With Web 1.0?

Here are some differences between Web 1.0 (a backronym) and Web 2.0:

Web 1.0	Web 2.0
Proprietary, closed access	Open access, data liberation
Standalone, firewalls	Dynamic, Participative, non-hierarchical
Publishing (websites)	Participation (blogs, comments)
Stickiness	Syndication, RSS
Microsoft Word	Google documents
Britannica Online	Wikipedia
"Pull" information	"push" (information comes to you)
Portal	Search
Medical directories, bookmarks, favourite sites (taxonomy)	Social tagging (folksonomies)
Disparate pieces	Integrated, mashed
HTML	XML (eg. RSS, atom)
E-mail alerts, listservs	RSS readers
Reading	Reading and writing

Web 1.0 versus Web 2.0

Why Use Web 2.0?

Emergency physicians, and doctors, in general, are constantly communicating with one another about medicine whether **formally** (journals, conferences, meetings, CME sessions, etc) or **informally** (on the floor, during breaks, online, at home, etc). Because of this, Web 2.0, which epitomizes **constant communication**, is a natural tool for doctors to use.

According to [Pat Croskerry](#), the environment that emergency physicians work in is a '[Perfect Storm](#)' for medical error. We work in a **time-critical, information limited, pressure cooker environment**. To thrive and survive we need to constantly maintain and grow our **foreground knowledge** (used for 'flesh and blood' decision making to care for our patients and solve

clinical problems) as well as our **background knowledge** (the core content and basic sciences that we need to understand the language of medicine, to teach, and to pass exams).

ED Knowledge Needs



We need to know a lot, we need to know it now, and often we don't know what we need to know until we need to know it... Where can we turn?

Web 2.0 of course — you don't want to be stuck using old textbooks chained to the desk for the rest of your career do you?



iPhone versus Books

What Can Web 2.0 Be Used For?

Emergency Physicians can use Web 2.0 for:

- Searching and sourcing information
- Sorting, saving and storing information
- Staying up-to-date
- Sharing information
- Social networking

What Are Web 2.0 Resources?

There are a diverse range of Web 2.0 resources relevant to Emergency Physicians and which

can impact on our daily practice.

These include:

Blogs

[Blogs Rankings and Rounds](#) — [When is a blog not a blog?](#) — [Emergency medicine blog database](#)

Microblogging tools

[Medical Twitter](#) — [Blogs Rankings and Rounds](#)

Podcasts

[Podcasts for Emergency Physicians](#) — [Podcast Database](#)

Feeds and Aggregators

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Wikis

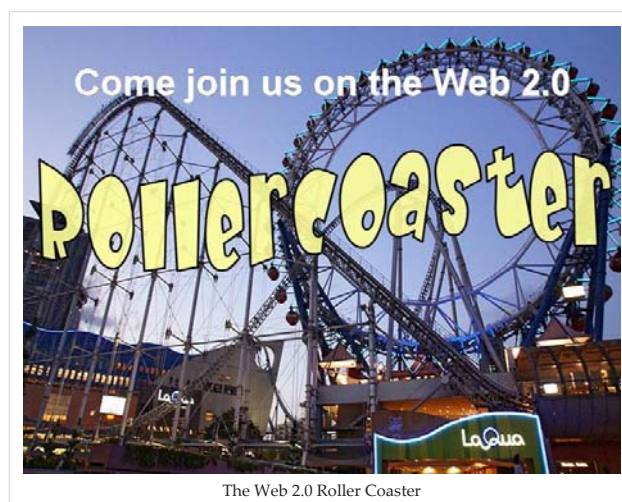
such as [OzEMedicine](#)

Alternative search engines

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Search engine reviews:

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Further Reading:

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DavidRothman.net ([@davidlrothman](#)) — [List of medical wikis](#)

Dr Shock ([@drshock](#)) — [How and Why Junior Physicians use Web 2.0](#)

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 Webicina — [Medicine in Second Life](#) — [How to keep yourself up-to-date in medicine](#)

From the 'mainstream' published literature:

Berners-Lee T, Hendler J, Lassila O. [The semantic web](#). Sci Am 2001; 10 May.
 Boulos M, Moramba I, Wheeler S. [Wikis, blogs and podcasts: a new generation of web-based tools for virtual collaborative clinical practice and education](#). BMC Med Educ 2006; 6: 41.
 Giustini, D (@giustini). [How Web 2.0 is changing medicine](#). BMJ 2006; 333:1283 — [Web 3.0 and medicine](#). BMJ 2007;335: 1273-1274
 McLean R, Richards BH, Wardman JI. [The effect of Web 2.0 on the future of medical practice and education: Darwinian evolution or folksonomic revolution?](#) MJA 2007; 187 (3): 174-177
 Smith R. [What clinical information do doctors need?](#) BMJ 1996;313:1062-1068 (26 October)

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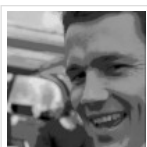
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About Chris Nickson

An [oslerphile](#) suffering from a bad case of knowledge [dipsosis](#). Key areas of interest include: emergency medicine, critical care, toxicology, tropical medicine, clinical epidemiology, history, literature and the internet-learning revolution. [@precordialthump](#)

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