

# The Power 10: Most Cited and Read Articles in the *Advanced Emergency Nursing Journal*

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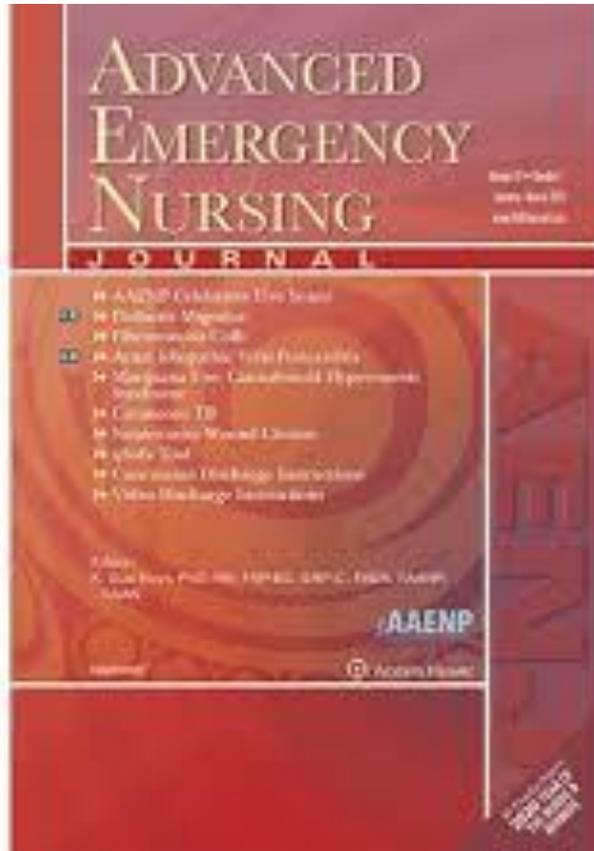
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# Objectives

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1. Examine the core findings of the top 10 most cited articles, their contributions to emergency care knowledge, and their influence on clinical practice.
2. Examine clinical decision- making skills for the treatment plan for selected emergency patients.
3. Identify recurring themes, methodologies, and areas of interest across these highly cited works, highlighting how they have shaped medical advancements and future research directions.
4. Provide emerging treatment and management for emergency department patients.



# The Power 10

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- Top Ten 2024 Articles viewed on Ovid
- Full text downloads
- International Journal
- AAENP societal journal

# #1: Acute Hyperkalemia Management in the Emergency Department

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Acute hyperkalemia is characterized by high concentrations of potassium in the blood that can potentially *lead to life-threatening arrhythmias* that require emergent treatment.

Therapy involves the utilization different agents

- all targeting different goals of care.

Weant, K. A., & Gregory, H. (2024). Acute Hyperkalemia Management in the Emergency Department. *Advanced Emergency Nursing Journal*, 46(1), 12–24.

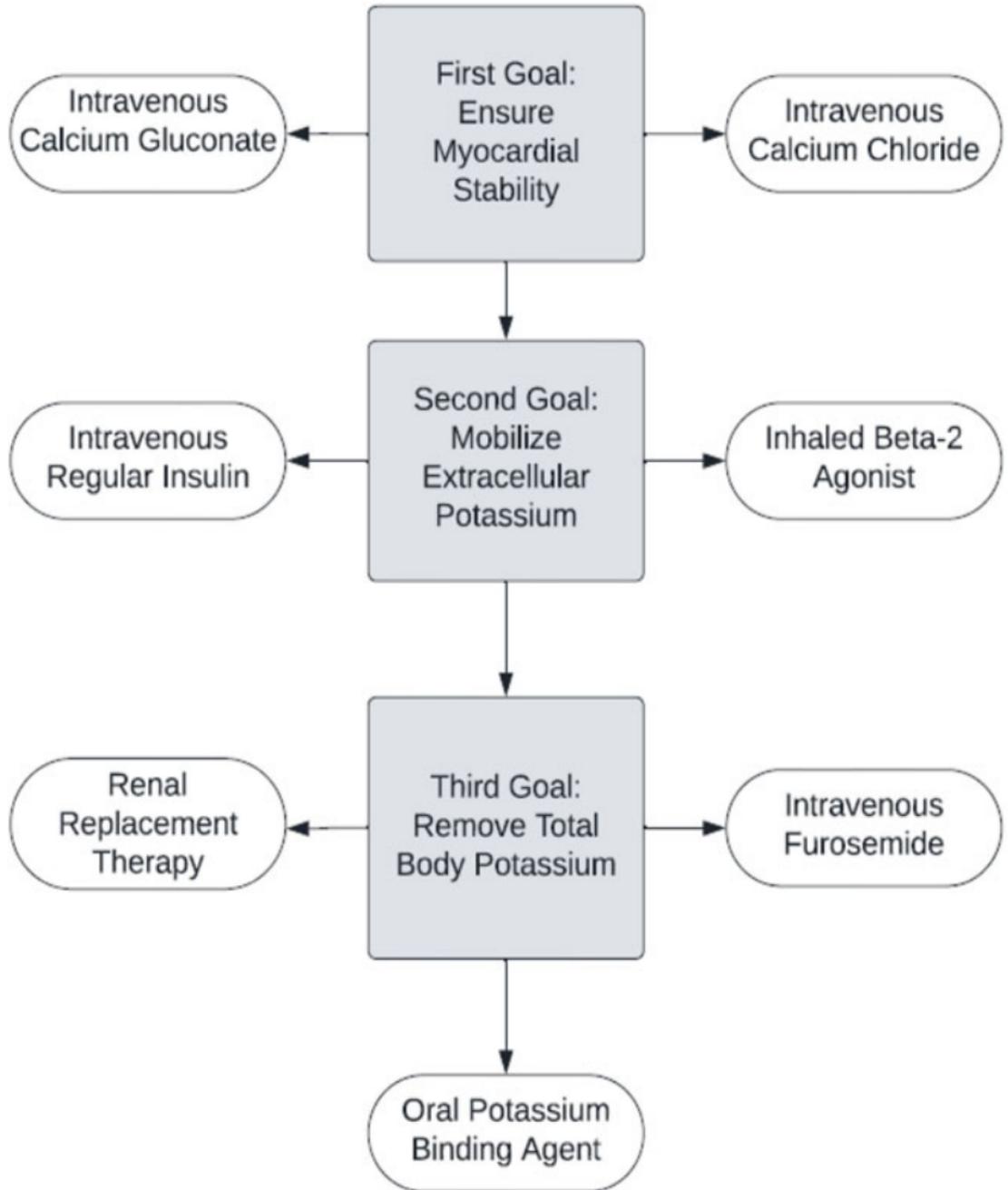
**Table 1.** Frequent patient characteristics associated with emergency department hyperkalemia presentations<sup>a</sup>

Acute/chronic kidney disease
Diabetes mellitus
Rhabdomyolysis
Hypoaldosteronism
Heart failure
Sickle cell disease
Drug-induced
• Angiotensin-converting enzyme inhibitors
• Angiotensin II receptor blockers
• Spironolactone
• Beta-blockers
• Trimethoprim
• Nonsteroidal anti-inflammatory agents
• Digoxin
• Potassium supplementation
• Tacrolimus

*Note.* From “Hyperkalaemia in the Emergency Department: Epidemiology, Management and Monitoring of Treatment Outcomes,” by K. Pollack, K. R. Manning, J. Balassone, C. Bui, D. M. Taylor, and S. E. Taylor, 2022, *Emergency Medicine Australasia*, 34(5), pp. 751–757.

<sup>a</sup>Selective list.

# Acute Hyperkalemia Management in the Emergency Department



**Table 2.** Pharmacotherapy options for treating acute hyperkalemia in the emergency department

<b>Pharmacotherapy</b>	<b>Dose</b>	<b>Onset of action of therapeutic effect</b>	<b>Adverse effects</b>
Calcium chloride, 10%	1 g IV (10 ml)	5–10 min	Extravasation; hypotension; flushing; bradycardia; nausea; vomiting
Calcium gluconate, 10%	1 g IV (10 ml)	5–10 min	
Insulin, regular	5 units IV	15 min	Hypoglycemia
Albuterol	10–15 mg inh/neb	30 min	Tachycardia; tremor; palpitations
Furosemide	20 mg IV <sup>a</sup>	Unknown	Hypotension; hypovolemia; hyponatremia; ototoxicity
Bumetanide	1 mg IV <sup>a</sup>	Unknown	Hypotension; hypovolemia; hyponatremia; ototoxicity
Sodium zirconium cyclosilicate	10 mg orally	60 min	Gastrointestinal upset

*Note.* inh = inhaled; iv = Intravenous; neb = nebulized. From “Management of Severe Hyperkalemia Without Hemodialysis: Case Report and Literature Review,” by V. Carvalhana, L. Burry, & S. E. Lapinsky, 2006, *Journal of Critical Care*, 21(4), pp. 316–321, and “Hyperkalemia Management in the Emergency Department: An Expert Panel Consensus,” by Z. Rafique, F. Peacock, T. Armstead, J. J. Bischof, J. Hudson, M. R. Weir, and J. Neuenschwander, 2021, *Journal of the American College of Emergency Physicians Open*, 2(5), p. e12572.

<sup>a</sup>Or home dose intravenously if applicable.

# Acute Hyperkalemia Management in the Emergency Department

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- Common presentation to the ED.
- Substantial morbidity and mortality if not emergently corrected.
- Multiple agents exist to help manage this presentation.
- Important to tailor therapies to the individual patient and balance the risks and benefits of each therapy to ensure optimal patient outcomes.

# #2: Alcohol Withdrawal Syndrome

## Improving Recognition and Treatment in the Emergency Department

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- Alcoholism as a Health Issue
- Accounts for up to **62%** of emergency department (ED) visits in the U.S.
- Alcohol Withdrawal Syndrome (AWS) can lead to poor patient outcomes if not managed early.
- Objective of the QI Project
  - Examine the benefit of early use of Alcohol Use Disorders Identification Test (AUDIT C) and Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-ar) in the ED.
  - Aim: Avoid escalation of care and improve outcomes for patients with AWS.

Glann, J. K., Carman, M., Thompson, J., Olson, D., Nuttall, C., Fleming, H., & Reese, C. (2019). Alcohol Withdrawal Syndrome: Improving Recognition and Treatment in the Emergency Department. *Advanced Emergency Nursing Journal*, 41(1), 65–75. <https://doi.org/10.1097/TME.0000000000000226>

# Alcohol Withdrawal Syndrome

## Improving Recognition and Treatment in the Emergency Department

### QI Project Design

- Single-group, pre-/posttest design.
- 35 ED staff surveyed for baseline knowledge; attended education sessions led by an advanced practice nurse.



# Alcohol Withdrawal Syndrome

## Improving Recognition and Treatment in the Emergency Department

### Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

**Nausea/Vomiting** - Rate on scale 0 - 7

- 0 - None
- 1 - Mild nausea with no vomiting
- 2
- 3
- 4 - Intermittent nausea
- 5
- 6
- 7 - Constant nausea and frequent dry heaves and vomiting

**Tremors** - have patient extend arms & spread fingers. Rate on scale 0 - 7.

- 0 - No tremor
- 1 - Not visible, but can be felt fingertip to fingertip
- 2
- 3
- 4 - Moderate, with patient's arms extended
- 5
- 6
- 7 - severe, even w/ arms not extended

**Anxiety** - Rate on scale 0 - 7

- 0 - no anxiety, patient at ease
- 1 - mildly anxious
- 2
- 3
- 4 - moderately anxious or guarded, so anxiety is inferred
- 5
- 6
- 7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

**Agitation** - Rate on scale 0 - 7

- 0 - normal activity
- 1 - somewhat normal activity
- 2
- 3
- 4 - moderately fidgety and restless
- 5
- 6
- 7 - paces back and forth, or constantly thrashes about

**Paroxysmal Sweats** - Rate on Scale 0 - 7.

- 0 - no sweats
- 1 - barely perceptible sweating, palms moist
- 2
- 3
- 4 - beads of sweat obvious on forehead
- 5
- 6
- 7 - drenching sweats

**Orientation and clouding of sensorium** - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4

- 0 - Oriented
- 1 - cannot do serial additions or is uncertain about date
- 2 - disoriented to date by no more than 2 calendar days
- 3 - disoriented to date by more than 2 calendar days
- 4 - Disoriented to place and / or person

**Tactile disturbances** - Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"

- 0 - none
- 1 - very mild itching, pins & needles, burning, or numbness
- 2 - mild itching, pins & needles, burning, or numbness
- 3 - moderate itching, pins & needles, burning, or numbness
- 4 - moderate hallucinations
- 5 - severe hallucinations
- 6 - extremely severe hallucinations
- 7 - continuous hallucinations

**Auditory Disturbances** - Ask, "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?"

- 0 - not present
- 1 - Very mild harshness or ability to startle
- 2 - mild harshness or ability to startle
- 3 - moderate harshness or ability to startle
- 4 - moderate hallucinations
- 5 - severe hallucinations
- 6 - extremely severe hallucinations
- 7 - continuous hallucinations

**Visual disturbances** - Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"

- 0 - not present
- 1 - very mild sensitivity
- 2 - mild sensitivity
- 3 - moderate sensitivity
- 4 - moderate hallucinations
- 5 - severe hallucinations
- 6 - extremely severe hallucinations
- 7 - continuous hallucinations

**Headache** - Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness.

- 0 - not present
- 1 - very mild
- 2 - mild
- 3 - moderate
- 4 - moderately severe
- 5 - severe
- 6 - very severe
- 7 - extremely severe

- Procedure:**
1. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (ie. start on withdrawal medication). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.
  2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet. Document administration of PRN medications on the assessment sheet as well.
  3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

## Postimplementation Findings

- Improvement in test scores after education.
- No significant difference in the use of AUDIT-C or CIWA-Ar in the ED.
- No significant reduction in length of stay (LOS) for patients with CIWA-Ar ordered.

## Barriers to Implementation

# Alcohol Withdrawal Syndrome

## Improving Recognition and Treatment in the Emergency Department

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### Clinical Implications

- Early identification and treatment of AWS in the ED can be beneficial.
- Advanced practice nurses play a critical role in improving early recognition and management of AWS in the ED.

# #3: Atopic Dermatitis: A Common Pediatric Diagnosis That Is Not Just Another Rash



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Gooch, M. D., & Jordan, K. S. (2023). Atopic Dermatitis: A Common Pediatric Diagnosis That Is Not Just Another Rash. *Advanced Emergency Nursing Journal*, 45(3), 195–205.

<https://doi.org/10.1097/TME.0000000000000468>

**Table 1.** American Academy of Dermatology's diagnostic criteria for atopic dermatitis

Clinical features	Description
<b>Essential</b>	
Pruritus	
Eczema	
Chronic or relapsing history	
Characteristic morphology with age-specific patterns	
<b>Important</b>	
Early age of onset	Onset between 2 and 6 months of age
Atopy	Personal or family history or both; IgE hyperreactivity
Xerosis	
<b>Associated</b>	
Atypical vascular responses	Facial pallor or white dermographism
Perifollicular lesions	Keratosis pilaris, perifollicular accentuation
Ocular or periorbital changes	Hertoghe's sign (thinning or loss of the lateral aspect of the eyebrows)
Regional findings	Perioral changes, periauricular lesions, pityriasis alba, hyperlinear palms, ichthyosis
Scratching-related chronic lesions	Lichenification, prurigo lesions

Adapted from Napolitano et al., 2022; Sidbury & Kodama, 2019; Ständer, 2021.



# Atopic Dermatitis: A Common Pediatric Diagnosis That Is Not Just Another Rash



## #4: Impetigo

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Johnson, M. K. (2020). Impetigo. *Advanced Emergency Nursing Journal*, 42(4), 262–269.  
<https://doi.org/10.1097/TME.0000000000000320>



# Impetigo

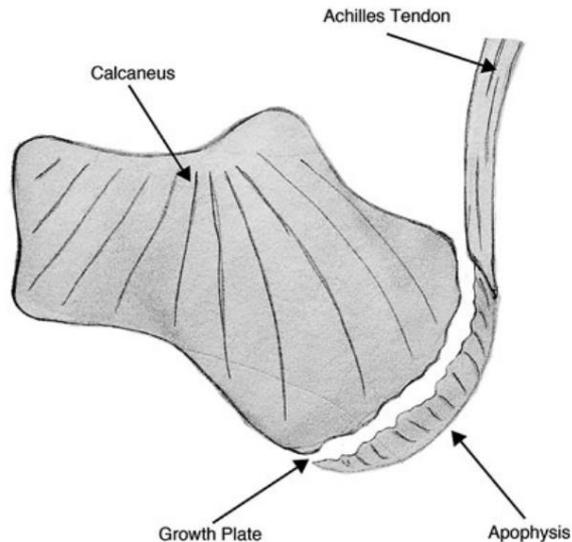


**Table 1.** Impetigo differentials

<b>Diagnosis</b>	<b>Differentiating feature</b>
<i>Nonbullous impetigo differentials</i>	
Contact dermatitis	History of exposure to chemical or physical irritants.
Scabies	Multiple, small, erythematous papules. Widely distributed. Rarely with isolated lesions. Primarily intertriginous regions. Burrows may be visible. Can occur in conjunction with impetigo or lead to secondary impetigo infection.
Dermatophyte infections (tinea)	Annular patch with raised border, spreads centrifugally with central clearing.
Eczema herpeticum	Atopic dermatitis with secondary herpes simplex virus infection. Cutaneous pain. Punched out erosions. Hemorrhagic crusts and vesicles.
Herpes simplex	Painful vesicular lesions. Can cause systemic symptoms depending on location of lesions.
<i>Bullous impetigo differentials</i>	
Drug eruption	Morbilliform eruption. History of drug exposure in days to weeks preceding rash.
Burns	History of thermal, chemical, or radiation burn.
Insect bites	Relatively sudden onset. Inflammatory, localized reaction at site of punctured skin. Pruritic area of erythema and edema.
Contact dermatitis	Exposure of sensitive skin to irritants (soap, urine, etc.). Dry, erythematous, cracked skin surface at area of contact with irritant.
Autoimmune blistering disease	Varies. Generally accompanied by some level of systemic inflammatory symptoms.
Varicella	Preceded by prodromal symptoms (fever, malaise, pharyngitis). Vesicular, pruritic rash with lesions in various phases. Inquire about vaccination status.

# #5: Sever's Disease (Calcaneal Apophysitis)

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**Figure 1.** Calcaneal apophysis is located posterior to calcaneus. Calcaneal apophysis is the insertion site of the Achilles tendon. Illustration is the original artwork by Nicole Eaton.

Ramponi, D. R., & Baker, C. (2019). Sever's Disease (Calcaneal Apophysitis). *Advanced Emergency Nursing Journal*, 41(1), 10–14.  
<https://doi.org/10.1097/TME.0000000000000219>

# #6: Postpartum Hemorrhage: Emergency Management for Uncontrolled Vaginal Bleeding



Wilbeck, J., Hoffman, J. W., & Schorn, M. N. (2022). Postpartum Hemorrhage: Emergency Management for Uncontrolled Vaginal Bleeding. *Advanced Emergency Nursing Journal*, 44(3), 213–219.

<https://doi.org/10.1097/TME.0000000000000421>

## **Box 1. Primary etiologies of postpartum hemorrhage**

Uterine atony  
Uterine inversion  
Lacerations  
Retained placenta  
Abnormally positioned or adhered placenta  
Coagulopathies

*Note.* From ACOG (2017).

	Assessments & Communications	Actions
<b>On Initial Presentation</b>	<ul style="list-style-type: none"> <li>Quantify blood loss &amp; vital signs</li> </ul>	<ul style="list-style-type: none"> <li><b>All postpartum women to receive oxytocin 10 units IM and fundal massage following birth regardless of blood loss</b></li> </ul>
 <b>Identify Significant Blood Loss</b>	<ul style="list-style-type: none"> <li>Cumulative blood loss &gt; 500mL, or HR <math>\geq</math> 110, BP <math>\leq</math> 85/45, O2 sats &lt; 95% or symptoms of hypovolemia</li> </ul>	<ul style="list-style-type: none"> <li>If significant blood loss identified, increase monitoring</li> <li>Consider etiology using the mnemonic <b>4Ts</b> <ul style="list-style-type: none"> <li>Tone (uterine atony)</li> <li>Trauma (lacerations, uterine rupture)</li> <li>Tissue (retained placental fragments)</li> <li>Thrombin (coagulopathies)</li> </ul> </li> </ul>
<b>Stage 1</b> Blood Loss > 500mL	<ul style="list-style-type: none"> <li>Increase monitoring of vital signs to every 5 minutes; record cumulative blood loss (CBL) every 5-15 minutes</li> <li>Careful inspection &amp; good exposure of perineum and pelvic structures</li> <li>Prepare team and medications for potential worsening condition</li> </ul>	<ul style="list-style-type: none"> <li>Ensure large-bore IV access &amp; provide bolus</li> <li>Oxytocin IV infusion – increase rate</li> <li>Methergine 0.2 mg IM if not hypertensive</li> <li>Repeat fundal massage, empty bladder &amp; keep warm</li> <li>Type &amp; crossmatch for 2 units PRBCs</li> <li>Ongoing search/treatment of 4T etiologies</li> </ul>
<b>Stage 2</b> Continued bleeding; Total Blood Loss of 1000-1500mL	<ul style="list-style-type: none"> <li>Ensure OB at bedside</li> <li>Vital signs &amp; CBL every 5 minutes</li> <li>Advance sequentially through actions and targeted treatments based on etiology</li> <li>Mobilize/coordinate blood bank support</li> <li>Anticipate volume &amp; blood needs</li> </ul>	<ul style="list-style-type: none"> <li>Bimanual Fundal massage</li> <li>Hemabate 250mcg IM or Misoprostol 600-800 mg</li> <li>Ensure placement of 2<sup>nd</sup> large-bore IV access</li> <li>Transfuse 2 units PRBCs on warmer based on clinical presentation; do not wait on labs</li> <li>Consider thawing 2 units FFP</li> <li>Send additional labs, including DIC panel</li> <li>Move patient to Labor &amp; Delivery suite or OR as able</li> </ul>
<b>Stage 3</b> Total Blood Loss > 1500mL, or > 2 units PRBCs given or VS unstable or suspicion of DIC	<ul style="list-style-type: none"> <li>Activate mass transfusion protocol</li> <li>Ensure definitive surgical intervention &amp; transfusion therapy</li> <li>Involve social worker, adult intensivist as available</li> </ul>	<ul style="list-style-type: none"> <li>Aggressive balanced transfusion, with near 1:1 ratio of PRBCs:FFP; provide 1 platelet apheresis pack per 4-6 units PRBC</li> <li>Placement of central line</li> <li>Repeat labs including coagulation panel and blood gas</li> </ul>

Ongoing Assessment of Quantified Blood Loss & Vital Signs

**Figure 1.** Postpartum hemorrhage management for emergency care settings (ACOG, 2017, 2019; California Maternal Quality Care Collaborative, 2015). BP = blood pressure; DIC = disseminated intravascular coagulation; HR = heart rate; FFP = fresh frozen plasma; IM = intramuscular; IV = intravenous; OB = obstetrics; OR = operating room; PRBC = packed red blood cell.

# #7: Ethics: Crisis Standards of Care Simulation

Figure 1. Debriefing Questions
1) How are each of you feeling about the scenario right now?
2) What aspect of the scenario went well and why?
3) What aspect of the scenario didn't go well, or you would like to do over again?
4) What was your original differential diagnosis for these critically ill patients? How did that change throughout the case? What acted as a trigger to your thought process? Did it feel uncomfortable to change your working diagnosis?
5) Did you find it challenging to determine disposition for each of the patients?
6) How do you feel about your teamwork? Did you adhere to the algorithm to determine acuity and prognosis of the 3 patients?
7) Do you feel the algorithm was fair?
8) Did you deviate from the algorithm?
9) Do you feel that implicit bias entered into the algorithm?
10) If so, what was that bias and how did it impact your decision making and care?
11) Do you feel that it would be easier to follow the algorithm and determine disposition without involving the patient and family?
12) Did you experience moral distress with the ethical decision-making process?
13) Do you believe that is the ethically right way to make these decisions or should ethical decision-making involve the patient and family?
Key Moments
1) Other final thoughts or observations?
2) What was your key take away from this experience?

**Figure 1.** Debriefing questions. Adapted from “Debriefing Methods in Simulation-Based Education,” by G. Sahin and T. Basak, 2021, *Journal of Education and Research in Nursing*, 18(3), pp. 341–346.

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Fuller Switzer, D., & Knowles, S. G. (2024). Ethics: Crisis Standards of Care Simulation. *Advanced Emergency Nursing Journal*, 46(1), 71–81.

<https://doi.org/10.1097/TME.0000000000000498>

# #8: Managing Diabetes Mellitus in the Emergency Department

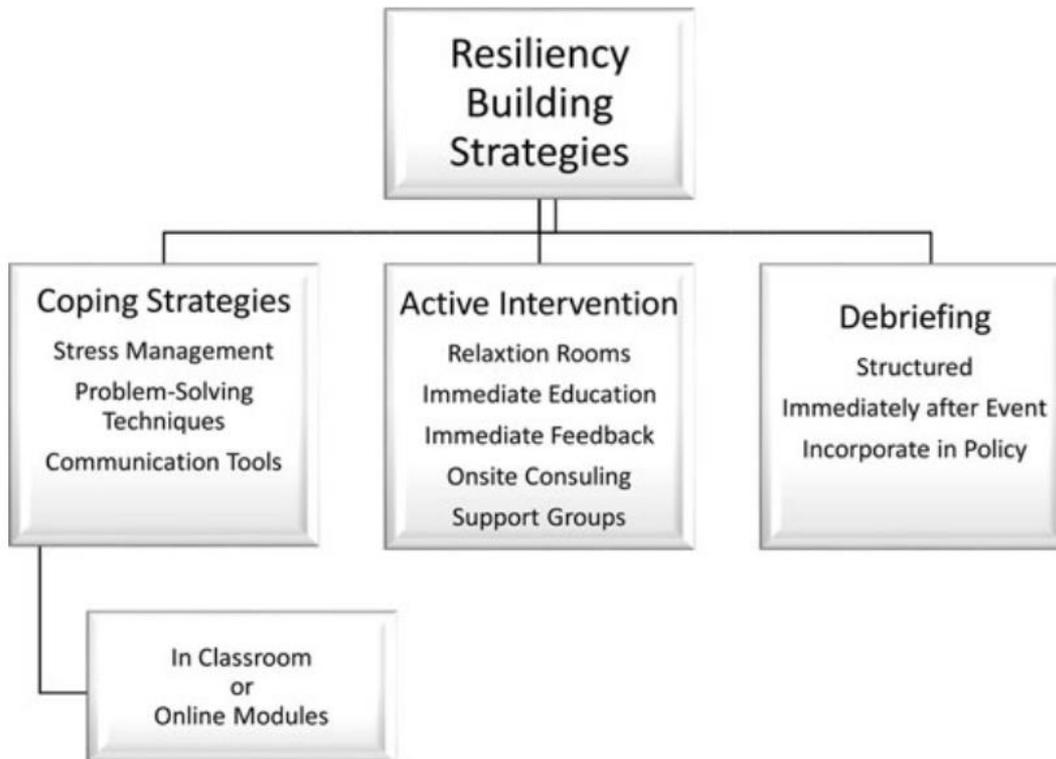
Burnett, C., Evans, D. D., & Mueller, K. (2024). Managing Diabetes Mellitus in the Emergency Department. *Advanced Emergency Nursing Journal*, 46(1), 58–70. <https://doi.org/10.1097/TME.000000000000500>

**Table 1.** Differences between DKA and HHS

<b>Variable</b>	<b>DKA</b>	<b>HHS</b>
<i>Defect</i>	Insulin deficiency	Insulin resistance
<i>Glucose intolerance</i>	Acute	Subtle
<i>Insulin sensitivity</i>	Normal	Decreased
<i>Serum insulin level</i>	Reduced	Variable
<i>Dehydration</i>	Moderate	Severe
<i>Blood glucose</i>	>250 mg/dl	>600 mg/dl
<i>pH</i>	<7.3	>7.3
<i>Serum osmolality</i>	<320 mOsm/kg	>320 mOsm/kg

*Note.* DKA = diabetic ketoacidosis; HHS = hyperglycemic hyperosmolar state. Table 1 created by Caitlin Burnett. Columns referenced from Hirsch and Emmett (2023a/b).

# #9: Nursing Burnout and Resilience Emergency Department



**Figure 2.** Resiliency building strategies.

Phillips, K., Knowlton, M., & Riseden, J. (2022). Emergency Department Nursing Burnout and Resilience. *Advanced Emergency Nursing Journal*, 44(1), 54–62.

<https://doi.org/10.1097/TME.000000000000391>

# #10: Pathophysiology and Treatment of Malignant Hyperthermia

**Table 3.** Dantrolene formulations and administration

	<b>Ryanodex (dantrolene sodium nanosuspension)</b>	<b>Dantrium and Revonto (dantrolene sodium)</b>
Dantrolene per vial	250 mg	20 mg
Volume of SWFI to reconstitute each vial	5 ml	60 ml
Final concentration of dantrolene per vial	50 mg/ml	0.33 mg/ml
MH crisis dose and administration	2.5 mg/kg iv push	2.5 mg/kg iv push
Postcrisis dose and administration	1 mg/kg every 4–6 hr iv push or 0.25 mg/kg/hr continuous iv infusion	1 mg/kg every 4–6 hr iv infusion over 1 hr or 0.25 mg/kg/hr continuous iv infusion
Prophylaxis dose and administration	2.5 mg/kg iv push 75 min before anesthesia	2.5 mg/kg iv infusion over 1 hr beginning 75 min before anesthesia

*Note.* iv = intravenous; MH = malignant hyperthermia; SWFI = sterile water for injection.

Gregory, H., & Weant, K. A. (2021). Pathophysiology and Treatment of Malignant Hyperthermia. *Advanced Emergency Nursing Journal*, 43(2), 102–110.

<https://doi.org/10.1097/TME.0000000000000344>



## AAENP Strategic Plan



**AAENP Mission Statement** – The American Academy of Emergency Nurse Practitioners promotes high quality, evidence-based practice for nurse practitioners providing emergency care for patients of all ages and acuities in collaboration with an interdisciplinary team.

**AAENP Vision Statement** – The preeminent specialty organization serving as the expert and unified voice for nurse practitioners in emergency care.

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# AAENP Strategic Plan

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We need your feedback!





*Advanced  
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Editor: K. Sue Hoyt

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- Nicole Martinez
- Wesley Davis



# References

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