



Highlights from this issue

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Simon David Carley, *Associate Editor*

There is no doubt that life in emergency medicine is tough at the moment. In the UK we face problems with workload, flow, space and staffing which combine to create significant stresses on the system. At times like this it can be easy to forget that there are many aspects of our speciality that still energise us. Research and teaching are core aspects of our job that we can continue to celebrate and this month's journal highlights many such projects.

Methamphetamine on the rise

Many of us will have seen a rise in the number of patients attending following methamphetamine use, though perhaps not as much as seen in the paper by Harnett *et al* from London. From 4 presentations in 2005 to 294 in 2018, a remarkable rise, often in conjunction with other drugs such as GHB/GBL. Many of the patients required critical care support and there is no doubt that this drug creates a significant burden on our services. This paper is a good example of why we must work alongside public health and harm minimisation programmes to support our communities. It's also worth noting that the majority of patients are younger men, a group who traditionally do not access other healthcare resources.

The risk of leaving a patient at home

I have recently started working more closely with prehospital colleagues and it was a real revelation to discover just how many patients are not conveyed to hospital (and how much effort goes into doing so). I suspect that many people, like me, worry more about the patients we leave at home (or send home from the ED) than those that we convey/admit. In this study by Laukkanen *et al* from Finland they followed up what happened from patients who were left at home. Overall the risks were very low, but there were some groups who appeared to subsequently need care in a tertiary centre. Abdominal pain, hyperglycaemia and fever all seemed to be more concerning.

Why do people come to the ED with minor complaints?

I'm sure that many of you are concerned about the large number of patients who attend the ED with minor conditions that could be treated elsewhere, but why do

these people attend us and are there any particular group who attend more than others. O'Caithan *et al* looked at this using patient vignettes which they presented to members of the public. They found significant differences in population groups about whether they would attend the ED. Availability, low resources, distress, speed and certain population groups were more likely to attend. This data may be helpful in targeting behaviours and offering alternative support to such groups in the future. Availability is something a little trickier for EM of course. The more efficient we are, the more available we are which in turn makes us more attractive for those seeking a convenient service. It's a feedback loop that needs careful thought and planning if we are to change attendance patterns for the future.

And specifically with URTIs...

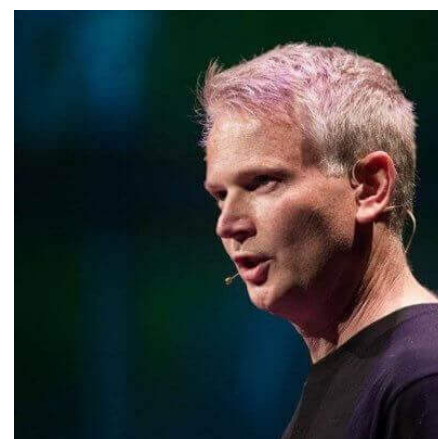
On a similar theme Chow *et al* look at why patients with URTIs come to the ED. They found that patients perceive Eds as more convenient, more able to investigate and of a higher standard than alternatives. As with the paper from O'Caithan above it seems that 'if we build it (an openly accessible ED) and make it available they will come (to the ED)'

Can we teach empathy?

Clinician empathy is positively associated with positive patient and staff outcomes, but can it be taught and/or encouraged through training programmes? It's a great question asked in a paper by Pettit *et al* in the US. This paper studied whether a structured programme of education and reminders could improve empathy in clinicians. Although there was a small change in patient perceived trust, it did not influence clinician empathy, so perhaps the answer is no, we cannot influence this through the usual means of education. I do wonder what influence pre-existing personality and environmental factors have on this measure and I'm sure we will see more research in this area in the future.

Blood pressure changes during pre-hospital RSI

Sudden blood pressure changes are something we try and avoid during RSI. In this



paper from Australia the authors looked at average blood pressure changes during RSI and as a population have shown that the changes are relatively small. However, we must also remember that pooled data can hide outliers, and it's the outliers that really matter. This paper suggests that on average they do well, but it should not make us complacent.

Strong magnets and bowel injury

Anyone working in paediatric emergency medicine will be fully aware that children have always ingested things that they probably shouldn't. A relatively recent addition to the very long list of ingested objects is strong magnets. These magnets, if ingested in pairs or more can link to each other and cause bowel ischaemia. Price *et al* present a case series this month that outlines typical presentations and outcomes. With roughly half of patients requiring surgery this is a significant concern and one to watch out for in the ED.

Gallbladder sonography

This month's SONO series addresses the right upper quadrant and especially the biliary system. There are some great tips and tricks here to help clinicians move beyond level one ultrasound capabilities. My experience is that this is quite a useful technique in the ED both to define pathology and thus to speed up and focus appropriate referrals. The SONO series has been a real success in the journal and we hope that it's helping spread the use of ultrasound across the readership.