Highlights from this issue

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IMA for VTE?

Ischaemia-modified albumin (IMA) once excited interest as an early marker of myocardial infarction, due to apparently high early sensitivity. But the sensitivity of a quantitative test is a function of the diagnostic threshold, and apparently high sensitivity can be achieved by using a low diagnostic threshold and sacrificing specificity. The diagnostic performance of a quantitative test is more appropriately examined by calculating the area under the receiver operating characteristic (AUROC) curve. This is the approach to analysis used by Hogg and colleagues in their evaluation of IMA for diagnosis of venous thromboembolism (VTE). By avoiding the jiggery-pokery associated with sensitivity and specificity, they produce meaningful but disappointing findings that IMA has little diagnostic value for VTE. I wonder what would happen if we analysed D-dimer for VTE in the same way? (***see page 455***).

Does this patient really need the emergency department?

The vexed question of whether patients with minor or moderate conditions could be managed in other settings is often informed by speculation and anecdote, so it is good to read Penson and colleagues who report hard data. They identified that over two-thirds of presenting conditions could have been managed in settings other than the emergency department, but patients typically felt that the emergency department was the only provider able to address their concerns. This belief was often based on being advised to attend by someone else, usually a health professional rather than friends and family. So are health professionals responsible for unnecessary emergency department attendances? (***see page 487***).

Why do patients with stroke delay calling an emergency ambulance?

The flipside of unnecessary emergency department attendances is explored in the study by Jones *et al*. They undertook semi-structured interviews with 50 patients admitted to hospital with acute stroke to identify features influencing delays between onset of symptoms and calling for emergency help, and to explore callers' experiences of the call. It emerged that many patients believed that the onset of acute stroke symptoms did not necessarily warrant immediate medical attention, and delays were often incurred by seeking other lay or professional advice prior to calling the emergency services. Can we educate the public to seek urgent medical attention when they suffer symptoms of acute stroke without producing even more unnecessary emergency department attendances? The experience of similar issues with acute chest pain and myocardial infarction suggests not (***see page 502***).

Improving the management of paracetamol poisoning

The management of paracetamol poisoning should be relatively straightforward, with clear guidelines and established treatments, but errors can occur and the consequences can be serious. Pettie *et al* introduced an integrated care pathway for the management of paracetamol poisoning at the Royal Infirmary of Edinburgh. They showed that documentation, the appropriateness of blood sampling and all aspects of intravenous acetylcysteine administration improved after implementation of the pathway. It would be interesting to know whether the pathway continues to be followed or whether, like productivity at the Western Electric Hawthorne Works, interest wanes over time (***see page 482***).

Post-concussive symptoms after head injury

Adolescence is hard enough without having to deal with the consequences of a head injury. Pickering *et al* studied 188 head injured patients aged 13–21 and in full-time education, and found that 24.5% had disabling symptoms 1 month after injury and 5.9% still had some symptoms after 6 months. As might be expected, a low Glasgow Coma Score at presentation predicted worse outcome. Somewhat less expected was that outcomes were also worse if assault was the mechanism of injury. Given the high incidence of head injury, the health impact of these findings is potentially substantial (***see page 451***).

A day in the life of emergency departments in Kenya

EMJ is an international journal and we are interested to describe the different ways in which emergency medicine is practised around the world. Wachira and colleagues report a 24 h snapshot of cases presenting to 15 public emergency departments in Kenya. The age profile of patients is relatively young, but the common treatments provided in the emergency department (wound care, fluid rehydration/resuscitation, management of acute brochospasm and splinting of fractures/sprains) will be familiar to practitioners throughout the world (***see page 473***).

Another use for ultrasound

A colleague of mine was told that he would fail his finals if he was not able to clinically assess the patient's jugular venous distension properly. I don't know if he will be reassured that things have moved on and ultrasound can now be used to measure jugular venous distension (US-JVD). Jang and colleagues measured US-JVD and B-type natriuretic peptide (BNP) in 119 patients with dyspnoea due to suspected congestive cardiac failure. The results showed some correlation between US-JVD and BNP, and that US-JVD ≥8 cm of water was sensitive but not specific for diagnosing congestive cardiac failure (***see page 477***).