Highlights from the issue

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A mask tells us more than a face (Editor's choice)

As ED clinicians we often pride ourselves on recognising the sickest patients by how they look, this skill is tacit and one that is the result of experience and longevity in emergency care. Our psychiatric colleagues have long accumulated significant research into disturbances in affect recognition in patients with mental illness, so I was intrigued to read in this issue a study by Kline and colleagues from the US which explored the variability of facial expression in patients with serious cardio pulmonary disease in emergency care settings. They found that patients with serious cardio pulmonary disease lacked facial expression variability and surprise affect. They suggest that stimulus evoked facial expressions in ED patients with cardiopulmonary symptoms may be a useful component of gestalt pre-test probability assessment. So, there may be some substance in one of the many satirical remarks made by Oscar Wilde that "A mask tells us more than a face" though I doubt his context was clinical.

It's not the age that matters

Accurately measuring weight in children presenting to the ED is essential and particularly crucial in resuscitation situations where interventions and drug dosages are calculated by weight. The APLS formula, $2 \times (\text{age} + 4)$ has been widely used in western ED's, but as obesity in our young people is becoming more common and children are taller than previous generations, this formula may fall short in terms of accuracy and patient safety. An alternative formula $(3 \times \text{age}) + 7$ by Luscombe and Owens (LO) has been suggested as more accurate than the APLS formula. Skrobo and Kelleher in Cork University Hospital Ireland undertook a retrospective study of 3155 children aged 1–15 years comparing both formulas to identify which one best approximates weight in Irish children presenting to the ED. They conclude that the LO is a safe and more accurate age based estimation over a large age range. Maybe it's time to review our practice but do read this paper and weigh up your own thoughts, no pun intended!

Not all suffering is pain

Pain is the commonest reason patients attend the ED. Our sometimes lack of appreciation and subsequent under-treatment of pain is often a source of distress and dissatisfaction which can result in uncharacteristic behaviour. However not all suffering is pain and we may find ourselves wanting when the cause of distress is emotional rather than physical. This issue features a prospective cohort study by Body and colleagues in Oxford which sought to describe the burden of suffering in the ED. Of the 125 patients included in the study many reported emotional distress particularly anxiety as well as physical symptoms. Indeed only 37 patients reported that pain was causing their suffering. It should not come as any surprise that being seen, information, reassurance, explanation, care by friendly staff and closure were the key themes reported as relieving suffering. This approach just represents best practice but in the mounting pressures of ED's worldwide it is all too easy to lose sight of the person and their need for compassion and understanding. Dismissing emotional suffering as perhaps someone else's problem is detrimental to our patients and ultimately ourselves. Do read this paper; it is a timely and salutary reminder of what we should be about, why we do the job we do and what patients expect of us. There is also a podcast with the Editor in Chief and the author. Find this online alongside this issue.

Best evidence or clinical acumen (Readers'choice)

As demands for emergency care and acuity of patients presenting continues to rise globally, ED clinicians are increasingly faced with making decisions to discharge patients from high acuity areas of the ED. Patient safety and well being should govern any decision to discharge a patient but many cases are complex and weigh heavily on clinicians making such decisions. Calder and colleagues in Canada conducted a real time survey of experienced ED physicians to determine how they perceive their discharge decisions and the impact on adverse events. The authors concluded that ED physicians in their study most often relied on clinical acumen rather than evidence based guidelines and that neither approach was associated with adverse events. They recommend further research which focuses on decision support solutions and feedback interventions.

The greater good

Pulmonary embolism (PE) is a leading cause of death in pregnancy and the post partum period and a devastating event for mother and baby. When accurately diagnosed and treated the risk of an adverse outcome is low. In this paper Goodacre and colleagues explore the options for imaging and discuss the evidence for using clinical features and biomarkers for the selection of women for imaging. Their review of the literature suggests that the harm of investigation with diagnostic imaging may outweigh the benefits but that clinical predictors could be used to identify women at higher risk who could be appropriate for imaging. They also state the need for further research around clinical predictors and particularly the use of D-dimer at a pregnancy—specific threshold.

Pearls of wisdom

There is little doubt that the emergency department is a quite unique environment that offers abundant opportunities for learning. Seizing and exploiting these opportunities is not always as straightforward as we would like it to be. The constant pressure to manage multiple patients and make decisions to refer, admit or discharge against the backdrop of a ticking clock often mitigates against the teachable moment however genuine our desire or commitment to teaching is. It's easy to feel impatient and exasperated by the seemingly slow pace of some learners when you are trying to maintain safety in a crowded department. On the plus side, however, learning in such an environment can instil a sense of urgency, something that cannot be learnt from a textbook. Nonetheless teaching and learning is integral to all our roles and so it was refreshing to read in this issue "Top 10 ideas to improve bedside teaching in a busy emergency department" by Green & Chen from California. We have probably all used some or all of these methods to teach in different circumstances but the authors imaginative use of a framework, of 'mnemonics' and easy to remember names such as "Aunt Minnie" and "Snapps" is amusing and lighthearted. In reading this paper, you may just find that pearl of wisdom for the next teachable moment.

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