CLINICAL MANAGEMENT

Clinical management—the series

Edited by Jim Wardrope

This is a new series in the journal whose main theme is management of “every day” clinical problems that come to our departments. “Doctor, my head/chest/hip hurts”. Patients present to us with symptoms and symptom complexes rather than in defined diagnostic groups. Biological diversity ensures that these symptoms will vary between patients; this is the challenge of accident and emergency medicine. The aim of this series of articles is to take a common presenting symptom, pleuritic chest pain for example, to give a pragmatic view on the management of this condition, examine the investigations useful in reaching a diagnosis, and to give guidance on the options for ongoing care of the patient.

These suggestions are not the only way to manage the conditions but the authors have been briefed to examine current evidence and guidelines and produce a workable framework of care of these problems. Some approaches will stimulate discussion and this is welcomed.

The second aim of the series is to attempt to further engage the readership in continuing medical education (CME). Reading the journal is most definitely CME and I am sure that you all read each issue from cover to cover. However to assist further education in each topic I have asked authors to highlight three key references that they consider essential reading around the subject. The authors have

also provided three questions, two that are answered by reading the text and one that is answered by reading the key references. If you wish to participate in this experiment, and it is an experiment, then you can send your answers to me. I will send you back an answer sheet. Those submitting answers will be able to enter this into their CME logbook as one hour of external CME.

Subjects in this series have been suggested by the editors and editorial board. If you wish to see other topics then please write to me with suggestions. Articles in the series include transient ischaemic attack, pleuritic chest pain, neck injury, vaginal bleeding, ischaemic chest pain, calf pain/deep venous thrombosis, and acute “hot joint” and abdominal pain in childhood. Many of you will have an area of expertise that you think would merit inclusion and may wish to volunteer to write an article. All expressions of interest are welcomed but be aware of the tremendous work involved and often countless redraftings after editorial and peer review comments.

An “interest in management” conjures up long hours of paperwork and endless committee meetings, but this series will hopefully stimulate interest in the clinical management of some of the difficult and controversial areas of our practice.

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Investigation of the head injured patient

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Two areas of clinical concern for both accident and emergency (A&E) and radiology staff are the investigation of head injured patients who attend acutely (within three days of injury) and, less frequently, the evaluation of those who present later with head injury symptoms. UK guidelines for clinical assessment¹ and radiological investigation² of head injury were introduced in 1984. Since then computed tomography has become increasingly available to A&E departments and in the light of more recent studies of their use it is appropriate that the guidelines are updated.

We present a review of recent studies and recommendations for the use of imaging and

other diagnostic techniques in acute head injury and in the following article deal with later presentation.

Patterns and mechanisms of injury

Of the million patients presenting to UK hospitals each year with head injury, almost half are children less than 15 years. Most injuries are due to falls (41%) and assault (20%) but road traffic accidents account for 58% of deaths and one third of those referred to neurosurgery.³

The case mix of head injury varies from centre to centre and this influences the yield of positive findings produced by the use of the

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