Highlights from this issue

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Female genital mutilation

Female genital mutilation (FGM) may be more common than we think (*see page 587*). In 16 months a single UK hospital (with a low percentage of population from high-risk countries) identified 34 women in antenatal services who had had the procedure performed. More than half of these women had been seen by the Emergency Department (ED) prior to the diagnosis, but FGM was not documented in the notes. The authors propose that in women presenting from high-risk countries, Emergency Physicians should consider direct questioning in the history to identify cases. This would allow women to access Gynaecology and psychological support, as well as to identify children in the family who may be at risk of FGM in the future. The accompanying commentary by Hanni Stoklosa (*see page 585*) gives a great summary on the topic and emphasizes the need to 'open our eyes and minds to FGM'.

Wellbeing and moral injury in Emergency Medicine

In Emergency Medicine we are exposed to dramatic suffering, violence, injustice, and the aftermath of events contravening our moral code, on a daily basis. It is not surprising that some cases have a negative psychological impact on us, causing us to ruminate and question ourselves. In this month's *EMJ*, we have two qualitative papers describing the specific elements of clinical events that cause emotional disruption, and how these may manifest as psychological symptoms or impact on an individual's life. The paper by Murray *et al*. (*see page 560*) introduces the concept of 'moral injury'. Despite the respondents being inexperienced medical students on a pre-hospital placement the themes will be familiar to clinicians. The paper may also change the way that you supervise and debrief your students on acute placements. Secondly, the qualitative study from Manchester by Howard *et al*. (*see page 595*) specifically focuses on the psychological wellbeing of Emergency physicians of varying grades. The degree and duration of disruption from clinical events may be more significant than we realise. We need to start recognising these emotions, talk more openly with colleagues about difficult cases, and consider whether there are interventions we can use to support our colleagues after predictable cases. The inevitable challenge is that what affects one person psychologically, may not have an impact on another. This month's 'View from Here' (*see page 650*) eloquently demonstrates the value of informal peer support in this context.

A new tool to clear the spine?

Most of us are familiar with the Canadian C spine rule (CCR) and the NEXUS rule to identify which patients require cervical spine imaging following trauma. Both of these were derived with plain films as the gold standard. This month, Inagaki and colleagues from Japan (*see page 614*) present their work developing a new decision rule for the use of cervical spine CT. This allows a GCS of 14 or 15, looks for cervical spine tenderness or neurological deficit, ignores distracting injury, and includes dangerous mechanisms of injury of fall down stairs, motorcycle RTC or fall from height. The authors quoted a 100% sensitivity and 51.9% specificity, (fracture rate of 4.1%) which beat the CCR. However, the study only included 927 patients (making it underpowered) and only 63% of patients had a CT for diagnosis so we won't be changing practice just yet.

What is normal?

What is your definition of hypotension to diagnose sepsis in an older patient? Does your guideline say <90mmHg? In this issue, Dutch researchers looked at the association between systolic blood pressure (SBP) and in-hospital mortality in ED patients older than 70 years of age admitted with a suspected infection (*see page 619*). Worryingly, in-hospital mortality increased linearly with as SBP declined from140mmHg to 100mmHg. Do we need dynamic blood pressure cut-offs for older patients (as we do for paediatrics) or do we need to review the presenting blood pressure in comparison to the patient's normal reading (like a peak flow in asthma)?

Violence reduction and EM

Treating patients following assault is Emergency Medicine's bread and butter. Prevention is also better than cure. In this month's *EMJ*, a study from a single Emergency Department in Cambridge (UK) analyses the changing epidemiology of assault (*see page 608*). This ED has an ISTV programme, meaning it shares information with local government, police and licensing authorities to direct interventions to reduce community violence. The authors found a 37% decrease in the rate of assaults attending ED over the ten year period, and disproportionately greater reductions in the number of patients attending at weekends or who could be discharged without follow-up. The reduction in violence is in line with national statistics so the authors can't state a causal relationship with their programme but it would be interesting to see if the pattern was the same in other ED's.

Going with the flow

We are all searching for the elusive solution to improve patient flow and reduce crowding in our Emergency Departments. An umbrella review of potential interventions to improve flow was performed by De Freitas and colleagues (*see page 626*). I would recommend you to read the summary of the 26 ideas that have been published by other centres but (spoiler alert!) there is only weak evidence for the effectiveness of any single intervention and as you would expect the studies are all very heterogenous. The 'winner' by a small margin... was fast tracking.