



Highlights from this issue

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Mary Dawood , Associate Editor**Headlines**

Every year approximately 1.4 million people attend the ED in the UK with a head injury. The National Institute for Health and Care Excellence (NICE) recommends routine CT imaging of all patients with mild head injury taking anti-coagulants within 8 hours of injury. The risk of adverse outcomes following mild head injury when taking a DOAC is uncertain, nonetheless to many of us it often feels like an unnecessary investigation and over exposure of a patient who is clinically well and without symptoms. So you may be interested to read a paper by Fuller and colleagues from Sheffield, who conducted an observational cohort study with the aim of estimating the risk of adverse outcome after mild head injury in patients taking DOACs to guide emergency department management. The primary endpoint was adverse outcome within 30 days, comprising: neurosurgery, ICH, or death due to head injury. They found the risk of adverse outcomes following mild head injury in patients taking DOACs appears low. The authors suggest these findings would support shared patient-clinician decision making, rather than routine imaging following minor head injury while taking DOACs. This might be music to your ears and indeed the radiologist, especially in the middle of the night.

Head home

Children are no exception where head injuries are concerned, it is estimated that more than 700 000 of them in the UK attend hospital every year with a head injury and less than 1% of these need neurosurgical intervention. Aldridge and his colleagues hypothesised that a proportion of these children could be screened and discharged at triage with appropriate safety netting by a nurse using a clinical decision tool. They prospectively screened all children (n1739) at triage over a 6 month period in 2018 using a mandated electronic 'Head Injury Discharge at Triage' questionnaire (HIDATq). Their findings suggest a negative HIDATq appears safe for their department and that potentially 20% of all children presenting with head injuries could have been discharged by nurses using the screening tool. This

figure increases to 50% if children with lacerations or abrasions were given advice and discharged at triage. They do point out however that a multi-centre study is required to validate the tool. Arguably any intervention that can safely minimise length of stay for children in the ED is worthy of consideration and will appeal to children and their carers.

Affairs of the heart

Chest pain continues to be a common presentation in the ED but medical advances and technology have changed and expedited the way we assess and manage these patients. Are we seeing more or less patients presenting with chest pain? Aalam and colleagues in the US undertook a retrospective descriptive study of trends in utilisation and care of ED chest pain visits from (2006 to 16) using data from the Healthcare Cost and Utilisation Project (HCUP) database, a national sample of US ED visits and hospitalizations. In their study, they describe demographic, care, and cost trends for chest pain over 11 years. Unsurprisingly, they found ED visits for patients with chest pain increased but inpatient admission rate declined from 19% in 2006 to 3.9% in 2016. Is this due to same day cardiac CTA and shorter Troponin testing times? I'll leave you to work this one out when you have read this paper.

Troponin or not?

Patients who present with chest pain often face lengthy delays in the ED to rule out ACS even though less than 10% are diagnosed with ACS. Previous studies have shown that up to 46% of cardiac troponin (cTn) testing in the ED is deemed inappropriate and results in not just wasted costs but unnecessary procedures. Moreover, it can also cause alarm and anxiety without adding value. Smith and colleagues in the US hypothesised that this low risk patient population does not benefit from testing and could be safely discharged following an ECG. They conducted a secondary analysis of the HEART Pathway Implementation Study. HEART Pathway risk assessments (HEAR scores and serial troponin testing at 0 and 3 hours) were

completed by providers on adult patients with chest pain from three US sites. Major adverse cardiac events (MACE) (composite of death, myocardial infarction (MI) and coronary revascularisation) at 30 days was determined. Their findings suggest that patients with HEAR scores of 0 and 1 represent a very-low risk group that may not require troponin testing to achieve a missed MACE rate. So maybe less delays in future?

The ED on your doorstep

Shielding our frail older patients has been an ongoing challenge in this COVID-19 pandemic, one hospital has bucked the trend and taken the ED to the patient. McNamara and colleagues in Dublin describe how a bespoke weekend service assessing older people who fell at home was expanded to meet the evolving needs of shielding older people in the pandemic. The team consisted of an advanced paramedic, an ED registrar and an occupational therapist in conjunction with local consultants in geriatric an emergency medicine. All three professionals travelled and attended calls together covering a wide catchment both urban and rural. The service carried with them OT equipment and had access to near patient testing and point of care ultrasound. Patients were registered to the ED by phone. They attended 592 patients in the first 105 days of operation 43 of whom were transferred to hospital, 41 being admitted. They also undertook 21 additional visits to care homes to give advice and infection control support. Do read this paper there is a lot of detail about set up and costs as well as examples of cases seen. It sounds like the quality care you would wish for your older relatives. It may be one of the silver linings of the pandemic and a viable pragmatic model for the future.

Sono case series

Don't forget to have a read of our Sono Case series. Brown and Shyy from the US focus on Soft tissue infections, Abscesses, Pyomyositis and Necrotizing Fasciitis, there is much to be learnt here.

ORCID iDMary Dawood <http://orcid.org/0000-0002-2535-2657>