Highlights from this issue

doi:10.1136/emermed-2012-202114

Kevin C Mackway-Jones, *Editor*

Ophthalmoscopy in the Emergency Department

As Petrushkin and colleagues point out ophthalmoscopy is a difficult but essential skill in the Emergency Department environment, particularly with regard to recognition of optic disc pathologies. In their short report they compare the sensitivity and specificity of the panOptic ophthalmoscope to that of traditional direct ophthalmoscopy in conditions comparable to those found in most EDs. While the newer instrument performs better than the traditional technique (and was preferred by the users) the actual clinical utility of doctors using both is worryingly poor. You probably have a view as to why this might be—to inform your thoughts turn to (***see page 1007***) to see the performance of trainee emergency physicians for yourselves.

Perfect World or Dark World

Emergency Department crowding is a problem just about everywhere and it is good to see that disciplines other than medicine are taking an interest. In a fascinating paper Baboolal and Operational Research collaborators use discrete event simulation to create models of the Emergency Unit (the Emergency Department itself as well as medical and surgical receiving wards) in Cardiff, Wales. Within their model it is possible to explore the effect of various changes to physical capacity and human resources. You need to read the whole paper for yourself (***see page 972***) to see the model in action—the relationship (in the model) between the physical resource requirements and the number of clinical decision makers (and how this is reflected in total cost) is particularly noteworthy. Of course a model is only a model and a perfect world doesn't exist (particularly one which never faces exit blocks), but this sort of collaborative approach between clinicians and other disciplines offers real opportunities for the future.

Alphabetical handover

Patient safety is the brash new kid on the clinical management block and she seems to spend a lot of her time shouting loudly that preventable harm is happening and can be avoided. It's certainly an arresting claim and one that deserves proper investigation and swift action if proven. Emergency Departments abound with clinical risk: high numbers of new, undifferentiated and unwell patients, multi-professional and multi-specialty staff in unfamiliar teams, time constraints and a high turnover to name but a few. Anything designed to reduce avoidable risk is to be welcomed. In a pair of papers Maisse Farhan and colleagues from Imperial College, London describe the development and implementation of a tool for ED shift handover that clearly works for them. The papers are worthy of close study (***see page 941, see page 947***); after reading them you'll find yourself looking Dirty Harriet, the patient safety cop, straight in the eye as she points her 0.44 magnum clipboard loaded with checklists at your head. You'll need to ask yourself one question: Do I feel lucky?

Well, do ya, punk?

Buscopan and/or Paracetamol in moderate abdominal pain

We all have hobby horses (or fixations!) and I have to admit that one of mine is a profound desire not to give patients with abdominal pain a dry mouth, blurred vision and a raised chance of urinary retention in addition to their presenting problems. I was delighted, therefore, to see the paper from Remington-Hobbes and co-workers that randomised patients with acute, moderately severe, undifferentiated abdominal pain into groups that received either oral paracetamol or intravenous hyoscine butylbromide alone or a combination of the two. To see what they found and to find out whether my fixation was justified or whether I need to eat my hat you'll have to read the paper (***see page 989***) for yourselves. Let's just say my mouth isn't dry from chewing straw.

To CRP or not to CRP, that is the question

Santos and colleagues from Sao Paulo, Brazil report on a problem that faces us all—the uncontrolled rise of the easily requested, expensive yet ultimately clinically unhelpful test. I'm sure we could all name a few tests that fall into this category—but they concentrate on the daddy of them all, that well known, non-specific marker of inflammation—the CRP. Their initial assessment of the problem involved an audit of current practise together with a review of the evidence of clinical utility. So far so normal. The most interesting storey they have to tell is, however, in terms of the intervention they designed to combat the problem. It is well worth getting this paper out and studying it (***see page 965***) as the lessons are generalisable to many situations and settings. Of particular note is the observation that changes can be maintained through permanent staff even in a situation where junior staff rotate very frequently.

They think it's all over

It wasn't just the athletes and the gamesmaker volunteers who had to prepare for the London 2012 Olympics—there was a considerable, hidden public health agenda too. Part of this was the development of an Emergency Department syndromic surveillance system to help monitor the nation's health. As Elliot and collaborators report (***see page 954***) in their paper describing the early part of this work, such a system is both feasible and useful. Gold medals all round.

and finally…

In a short report Reed and others from Edinburgh, Scotland report on a possible role for troponin assay in patients with syncope (***see page 1001***). In a linked commentary (***see page 1000***) Steve Goodacre discusses the potentially important implications of this finding and explores some of the methodological issues raised in reviewer and editorial committee comments. Both are well worth a read.