Highlights from this issue

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People who've met, spoken or corresponded with me will know I'm quite a fan of stupid questions. In fact, I'm such a fan that I actually had to google for "wacogne stupid questions" as I began to write this to ensure that I hadn't written exactly the same thing before. I think I've always been an asker of stupid questions—someone who takes as true the old saying "He who asks a question looks a fool for a minute; he who doesn't remains a fool for a lifetime". I have a vivid memory of working for an ageing physician during my very first jobs and being astounded by the asinine nature of his questions. It was only after the dual realisation that he asked the same category of questions as the wisest professors on the team, and that his really simple questions cracked open the issue at hand when you realised that you couldn't answer them, that I appreciated his quiet genius. I've continued to practise asking stupid questions, and although I'm a fair distance from both quiet and genius, I have much of the technique perfected now.

There are at least two categories of answers to stupid questions. One is "You should have known that all along". Into this, I'm going to place the question: "How do I understand and use a direct antiglobulin test?" I've probably requested this test hundreds of times over the years, and have had a vague idea that it tells me something, and that I can rely on it. Thanks to Keir, Agpalo, Lieberman and Callum in an Interpretations paper this month, I can be much more confident that I actually understand it (***see page 198***). I hope that Sam Behjati, the section editor, will take it as a compliment when I say he's got a talent for asking stupid questions.

The other big category of stupid question is where there actually is no good answer. It is a particularly interesting stupid question when various people are very passionate in their opinion that they do have the right answer. A good example of this for me is the choice between aminophylline and salbutamol in the management of acute severe asthma in children. My journey through this has been as a rather bemused passenger. Most units I worked in as an SHO and then a registrar in the UK favoured aminophylline. Then I went to Australia, to Brisbane, where salbutamol was king. Then I came back to the UK and got used to aminophylline again. Then, a few years ago, locally my team changed to salbutamol. On each occasion folk would tell me—with passion—why the current thing was better than the previous thing. For me, the main issue was to remember that you would create chaos if, in the heat of the moment, you requested the wrong thing—meaning the unfashionable one. And also, that if you were in a tight spot, adding in the other one would sometimes help. In a paper from Neame, Aragon, Fernandes and Sinha, the authors set out the pros and cons for each (***see page 215***). I'd recommend their table 1 as an excellent way of easing yourself in to this debate. And, for the record, reading this I'd say that on balance I'd support our local recommendation of salbutamol as a first line—but it's a close run thing. This paper is this month's Editor's choice.

One of the challenges in our newer, larger edition (do you like it?) is that there are too many papers for me to write about them all in this Epistle. Please don't assume that I don't like them—I'm really proud of our content, and I'm so pleased that we've been able to increase the number of pages—and number of papers—while continuing to help you answer your own stupid questions. Just a reminder that if you were thinking of writing, you should take a look at the blog, here: http://blogs.bmj.com/adc/ and do please get in touch.

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