



Highlights from this issue

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A gentleman is driving down a country lane, quite lost. He decides to ask for help, and spots a local yokel, in full-on cliché mode—meaning he’s sucking on a bit of straw and leaning on a five-bar gate. “Excuse me!” calls the driver. “Could you tell me the way to Worcesterdale?” The local thinks a while, sucks extra hard on his bit of straw, and eventually says “Well. I wouldn’t have started from here...”

I’m quite sure that very many of our more complex situations in medicine, and even in broader life, could be nicely summarised in bad jokes. This one is helpful for the situation where someone has measured something and they have a result which isn’t entirely helpful. Nor is the advice offered by the boss of a friend of mine who asked him how to deal with an unexpected abnormal test result: “I’d build a time machine, go back in time, and not do the test in the first place”. But, here we are, in medicine, and someone has done the test and we are starting from here, not somewhere else.

Take neutropenia. Proper neutropenia is a terrible problem, and one which we rightly take very seriously. We have high-minded, and robustly evidence-based protocols for how to respond when we note that sick children are neutropenic, and when neutropenic children are sick. That’s a clinical problem, but

to be honest, it is straightforward. It’s a lot trickier when somebody has done a blood count and has demonstrated that someone is genuinely, statistically neutropenic, but only by a little bit. Rebecca James and Bob Phillips have written (*see page 282*) about how to respond to this range of neutropenias, and give a helpful framework for response to the issue.

In the UK, the Royal College of Radiologists have published a useful guideline about radiological investigation of suspected abuse. Sophie Halstead and colleagues look at the changes introduced by this update (*see page 309*), a decade after the earlier edition. There are some important improvements in practice which ask all of us to achieve higher standards for some of our most vulnerable patients. As ever with these papers, we see them as an alternative introduction to, but not a substitute for reading, the whole guideline.

Our interpretations section aims to guide us towards using tests more appropriately in the first instance. There are two great papers—Martin Hanna and colleagues look at the use of iron studies (*see page 321*), a subject which people have very strong opinions about, sometimes in proportion to how much they know about it. I strongly suspect that my use of iron studies will be much more rational having read this clear

paper. I particularly like the use of the phrase “In general, it is wise to avoid...”, and was wondering about talking to the section editors about including this phrase in all Interpretations articles. Perhaps all *Education & Practice* articles?

In another Interpretations, Gemma Batchelor and colleagues discuss the use of videofluoroscopy (*see page 313*). If you’re lucky enough to work in a centre where this is offered, you’ll doubtless be strongly encouraged in the correct use of the test by a gatekeeper, usually a speech and language therapist. It strikes me that good gatekeeping for some of the tests we do, although time intensive and requiring wisdom to deploy constructively, might be helpful. What if we had a gatekeeper for each time we were about to measure the neutrophils? Presently, we only do this for our more expensive tests, or the ones which are more obviously harmful. But what if we had someone leaning beside the five-bar gate and saying: “Look. Are you sure you want to start from here? Because you might cause yourself, and your patient, quite a few problems if you do...”

See you in the New Year—bit of a surprise for you in store too!

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