Pitfalls in EM

- Clinical pitfalls
- ‘System’ pitfalls
- Cognitive pitfalls
Errors of Cognition

• Which system are you thinking in?
  – System 1; fast, intuitive, pattern recognition
  – System 2; slow, deliberation / consideration
Errors of Cognition in EM

• Be aware of common cognitive errors
  – Anchoring, diagnosis momentum, outcome bias
  – Availability / recent case bias
  – Confirmation bias
  – Premature closure / search satisfaction
Risk Factors for Cognitive Error

- Cognitive overload
- High decision density
- Interruptions or distractions
- Emotional influences
- Time pressures
- Fatigue
- The patients we don’t like
Error-prone Presentations

- ‘Drunk’ head injury
- SAH
- Necrotising fasciitis
- # NOF
- Ectopic pregnancy
- ACS
- Elderly abdominal pain
- Missed #s (buckle, greenstick, scaphoid, facial)

- DKA
- Inferior MI
- Sickle Cell crisis
- Lower lobe pneumonia
- Leaking AAA
- Thoracic aortic dissection
- Ischaemic gut
- Re-attenders
- Patients on steroids
‘Drunk’ Head Injury

• Alcohol intoxication and accidental or deliberate head injury are often seen together.
• Alcohol and head injury may both cause reduced conscious level.
• We don’t want to CT every drunk patient.
• Examine the patient to assess risk.
• Close frequent observation and early review.
• Decision re: CT by 2 hours of observation.
• Drunks should start to sober up once they stop drinking.
SAH

• It’s all in the history of headache onset
• Thunderclap headache
• Syncope / pre-syncope, vomiting
• Family history
• Erroneous reassurances:
  – Neuro exam was normal
  – The headache improved with analgesia
  – The patient seemed too well and all the obs were normal
• Beware a new diagnosis of migraine in the ED
• May present with hip, groin, thigh or knee pain
• Some patients can still weight bear or walk, albeit with pain
• X-rays are not 100% sensitive
• In pathological # there may be no history of fall
• If clinically you suspect a # NOF but the x-ray doesn’t show a # the patient needs a CT
Necrotising Fasciitis
Necrotising Fasciitis

• Patient appears more unwell than you would expect for the area of ‘cellulitis’. Look at obs – raised RR, HR, temp. common

• Patient has pain that is out of proportion to what you see

• Palpable gas in the tissues is a late sign
Aortic Dissection

Differential Diagnoses
- Acute MI / ACS
- Gastro-oesophageal reflux / dyspeptic disease
- Pulmonary Embolism
- Pancreatitis
- Mechanical back pain
- Acute aortic insufficiency
- Pericarditis
- Myocarditis
Aortic Dissection

- Chest, neck or back pain – usually severe but sometimes mild
- Up to 10% are painless
- Pain ripping, tearing or commonly sharp in nature
- Onset abrupt; severity maximal at onset
- Associated nausea, vomiting, sweating
- Syncope (5-10%)
- Neurological symptoms (5%) if carotid or spinal artery involved

‘It looks like an MI but the ECG is normal’
Self-checking for Cognitive Errors

• What traps might I be falling into?
• What else can it be?
• Is there anything that doesn’t fit?
• Write down and re-consider your differentials.
• Is there more than one thing going on?
• Is this a case where I need to slow down?
Pitfalls of Autonomy

• **Autonomous** describes things that function separately or independently.
Avoiding the Pitfalls

• Be aware of the common pitfalls / high risk presentations
• Take a good history – it nearly always leads to the diagnosis
• Ask about co-morbidities, PMH and drugs – they may give you clues.
• Don’t ignore abnormal physiology
• Don’t ignore the bits that don’t fit
• When you can’t explain your findings don’t assume its all psychological
• If in doubt ASK (and ask early)