# Academic Emergency Medicine
# Editor-in-Chief Pick of the Month

"Meet 'em, treat 'em and street 'em" went the insipid aphorism. Well, I hope it *went*... away. Good riddance. I am happy to have not heard that apish phrase in about five years. Emergency care has evolved from a discipline of cowboys and aphorisms, into a specialty that demands the consideration of every patient interaction as a point along a continuum.

Emergency medicine researchers have recognized that there is a dearth of knowledge to help patients make informed choices over the first few weeks after unexpected injury, illness, and what may seem like minor trauma. Patients need to know the truth regarding their prognosis; addressing this gap in knowledge and communication will improve patient's lives. **In this month's AEM,** enlightened emergency care researchers work to evolve our discharge language from the vapid, "...if you don't feel better in 12 hours, return to the emergency department," towards "...you need to prepare for the possibility of not feeling better, and here is what you can do to help yourself."

This month's POTM includes both a research method and topic that warrants recognition. The title is aptly descriptive: **The Association Between Daily Posttraumatic Stress Symptoms and Pain Over the First 14 Days After Injury: An Experience Sampling Study** by Pacella et al. First, the authors were early adopters of an emerging research tool that we will see more often: structured texting to collect data in the follow-up period (it goes by the fancy name of ecological momentary assessment, or EMA, but really, it is just texting). Second, this paper addresses how we can better educate our patients about posttraumatic stress symptoms after minor trauma.

Figure 2 contains a pearl for your next shift. These data are novel, interesting, and important: a real-time report of pain for 15 days after minor trauma from 61 patients. This figure provides an evidence-based answer to the question asked by one in 10 patients: "Doctor, how long will I hurt? How much will I hurt?" Additionally, Pacella et al. teach us that persistent pain is associated with feelings of being "overly alert, jumpy, and/or having difficulty concentrating." However, they are careful

to note that full-blown PTSD is rare after minor trauma. These facts can formulate patient-centered communication instead of boilerplate protectionism. In the near future, we will treat minor trauma as a psychological event more than a physical event.

Best wishes,
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Editor-in-Chief, Academic Emergency Medicine

## Narrative Summary

**Zachary F. Meisel, MD, Associate Professor of Emergency Medicine at the Perelman School of Medicine at the University of Pennsylvania, places the EIC Pick into perspective in the emergency setting:**

A senior emergency physician and scientist recently challenged me. We were discussing a new research project using a large administrative claims database to identify risk factors for conversion from a new acute pain opioid prescription to chronic use. He was quite skeptical of the premise. Paraphrasing, he said, "a database — even a detailed one — isn't going to capture the nuances of each person's story that can lead to long term problems with pain medication." Pacella and team corroborate the insights of my astute colleague. Aspects of the injured patient experience, coping, and perceived social support drive marked variation in post-trauma pain. While I am not quite ready to give up on the hypothesis that there may be identifiable demographic and diagnostic risk factors for who develops chronic pain and/or chronic opioid use after an injury, the individual patient experience, doubtless, plays an important role in determining the trajectory of recovery. Well-conceived experience sampling methods, as described in **this paper**, are an important step in unlocking answers to this important public health conundrum.