Academic Emergency Medicine

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

Getting to the Heart of the Matter in Geriatrics

When I was moonlighting at a busy backwoods emergency department as a PGY-6 emergency medicine/internal medicine resident, I picked up the chart of an octogenarian who reported discomfort at the tip of his pinky. As I entered the exam room, I found a rugged Pennsylvania farmer who probably rarely complained about any physical ailment. His family quickly confirmed that impression and reported no significant past medical or surgical history with the caveat that he had probably seen a doctor three times in his adult life. Anxious to return to his farm chores, my patient hurriedly described a throbbing pain in the fifth digit. He remembered no injury and noted no associated symptoms. I saw nothing abnormal with his finger, so I reflexively ordered an EKG and troponin to exclude "atypical acute coronary syndrome." Twenty minutes later while wheeling the now grumpier farmer to the cardiac lab with a lateral wall STEMI, Cardiology patted me on the back for being an astute diagnostician.

Fast forward 20 years and Wang et al. provide retrospective evidence of troponin over-testing when older adults present to one academic emergency department. I have no reason to suspect their troponin ordering in an aging America differs from every other department across the land. Isn't our job to find every needle in a haystack diagnosis with a zero percent miss rate? Malpractice attorneys certainly paint that illustration of absolutism to patients and juries. Not once has a patient, hospital administrator, insurer, or lawyer ever thanked me for *not* ordering a test. Yet 20 percent of patients in this study had an elevated troponin and 93.8 percent of those were not ACS. Nonetheless, emergency physicians admitted everyone with an elevated troponin and none received a reperfusion intervention. Defining and avoiding emergency medicine over-testing, over-diagnosis, and over-treatment is a perplexing problem. One, vague complaints among older adults occur frequently and two, the number of baby boomers reaching senescence will continue to climb until 2035. Quantifying the optimal balance between patient safety and cost-effective inpatient decisions in a continually shifting healthcare policy environment seems to be a logical next step. Until then, consider incorporating and documenting shared decision making with older patients before reflexively obtaining troponins routinely.

Happy New Year,
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1. *Carpenter CR, et al.; Overtesting and the downstream consequences of overtreatment: Implications of "Preventing Overdiagnosis" for Emergency Medicine, Acad Emerg Med 2015; 22: 1484-1492.*

2. *Kuster T, et al. Combinations of symptoms in emergency presentations: prevalence and outcomes, J Clin Med 2019; 8: E345*
3. *Hogan TM, et al., Shared Decision Making to Improve the Emergency Care of Older Adults: A Research Agenda, Acad Emerg Med 2016; 23: 1386-139*