In his song “Kodachrome,” Paul Simon laments wasted time learning useless facts.

“When I think back
On all the crap I learned in high school
It's a wonder
I can think at all…”

The same can be said for medical school and, to some extent, residency. As Ebell et al. point out in this month’s AEM Pick of the Month, Accuracy of Signs and Symptoms for the Diagnosis of Community-acquired Pneumonia: A Meta-analysis, current literature teaches that a lot of what we learned on eternal medicine rounds about diagnosing pneumonia was no more useful than what they taught Paul Simon in high school. Egophony? Five percent sensitive. The good old pleural friction rub? Seven percent sensitive. Dullness to percussion? Fourteen percent sensitive. How about cough? Eighty-eight percent sensitive but only 18 percent specific. Fortunately, the “overall clinical impression” (i.e., gestalt) was a little better at 50 percent sensitive and 92 percent specific.

This paper is important because every emergency physician should be roughly aware of the sensitivity and specificity data in Table 2 of Ebell et al. This paper will serve as a valuable teaching reference on shift for years to come. Of course, the data in Table 2 are only as valuable as the gold standard used to define pneumonia and, speaking from experience, may I humbly say that the process of defining a criterion standard to diagnose pneumonia is more confounded than an essay comparing the pronoia
system of Byzantine feudalism with the Phonecian city-state. Or any other essay you wrote in high school.

Best wishes,
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