Doing what's necessary becomes doing what is possible

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Learning from necessity is the essence of what we publish in the journal. And the pandemic has proved a mother of invention for many authors. A recent multi-modal review investigated the scientific (and political) decisions that saw Sweden have a 10-fold higher COVID-19 death rate compared with neighbouring Norway.[1] An especially criticised aspect of the Swedish approach was management of infected older people, where the assumption was made that age-related comorbidity is the main factor factor predicting greater vulnerability. However, there is also an emerging concept of *immunosenescence* – the property of the immune system to vary with age, resulting in varying susceptibility to infection and response to vaccination. The clinical spectrum of COVID-19 is related to the spectrum of the immune response, so tying these two principles together is an important paper by Fogarty and colleagues looking at the maximal response of temperature and inflammatory response to COVID-19 infection.[2] Underpinning their results is the observation that the immune response to infection is complicated with discrete pathways that vary differently with age.

Since the start of the COVID-19 pandemic, the 40-step desaturation test has been advocated for triage of patients. We publish a first feasibility study of this test by Subbe and colleagues, providing normal ranges for the test in patients without COVID-19 and identifying challenges in the ability of patients to complete the test.[3] The paper focuses attention on the need for further clinical evaluation of such 'bedside tests', and we are delighted to publish such validation papers in *ClinMed* the way we have previously on point-of-care ultrasound.[4–7]

Clinical guidelines for common and specialty conditions are also important content for the journal. We present an expert consensus on the diagnosis and management of multisystem inflammatory syndrome in adults, a syndrome of hyper-inflammation affecting young adults that can result in devastating cardiogenic shock.[8] As the COVID-19 pandemic continues there are likely to be further increases in incidence of this complex immune-mediated condition. The consensus group proposes a system of regional teams to assess these often hard-to-diagnose patients.

The NHS was created as an instrument of social justice, with the promise of equal access to health outcomes, irrespective of socioeconomic status. Existing data have estimated that if socially deprived areas had survival rates similar to those of the most advantaged groups, one in ten diagnoses of cancer could be avoided. Jobling *et al* present a description of how GP referral rate varied dependent on deprivation, and also of how the socioeconomic background of patients diagnosed in a multidisciplinary diagnostic clinic could mitigate diagnostic yield compared to traditional pathways.[9] At the other end of the cancer pathway, King *et al* describe best supportive care pathway for patients with lung cancer not suitable for anti-cancer treatment.[10] They identify a cohort of patients who tend to be over-investigated and also identify the importance of identifying impaired renal function to support decision making.

Radiation-induced coronary artery disease is an increasing entity as cancer survival rates improve – it is now the second most common cause of morbidity and mortality in patients treated with radiotherapy for breast cancer and mediastinal malignancies. Given the prolonged latency after radiotherapy, and the often atypical presentation, White and colleagues present a timely review of clinical features and call for surveillance.[11] ■

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References

1 Brusselaers N, Steadson D, Bjorklund K *et al*. Evaluation of science advice during the COVID-19 pandemic in Sweden. *Humanit Soc Sci Commun* 2022;9:91.
2 Crooks CJ, West J, Morling JR *et al*. Age modifies both the maximal temperature and inflammatory response in patients with SARS-CoV-2 infection. *Clin Med* 2022;22:192–6.
3 Rhys GH, Wakeling T, Moosavi S *et al*. Feasibility and accuracy of the 40-steps desaturation test to determine outcomes in a cohort of patients presenting to hospital with and without COVID-19. *Clin Med* 2022;22:203–9.
4 Smallwood N, Dachsel M. Point-of-care ultrasound (POCUS): unnecessary gadgetry or evidence-based medicine? *Clin Med* 2018;18:219–24.
5 Smallwood N, Walden A, Parulekar P, Dachsel M. Should point-of-care ultrasound become part of healthcare worker testing for COVID? *Clin Med* 2020;20:486–7.
6 Nepal S, Dachsel M, Smallwood N. Point-of-care ultrasound rapidly and reliably diagnoses renal tract obstruction in patients admitted with acute kidney injury. Clin Med 2020;20:541–4.
7 Aujayeb A. Lung ultrasound in COVID-19. Clin Med 2020;20:e281.
8 Hookham L, Fisher C, Mason JJ *et al*. Understanding the diagnosis and management of multisystem inflammatory syndrome in adults (MIS-A) in the UK: results of a national Delphi process. *Clin Med* 2022;22:266–70.
9 Jobling ITR, Waddington C, Crawford SM. Piloting a novel cancer care pathway: socioeconomic background as a barrier to access. *Clin Med* 2022;22:241–5.
10 King J, Shas D, Hewitt K *et al*. The diagnostic pathway in lung cancer patients with best supportive care decisions: are there lessons to be learnt? *Clin Med* 2022;22:246–50.
11 Kirresh A, White L, Mitchell A *et al*. Radiation-induced coronary artery disease: a difficult clinical conundrum. *Clin Med* 2022;22:251–6.