Asthma is an increasing problem worldwide, particularly among women. Sex differences in acute asthma presentation, management, or outcome would imply important medical and economic implications. This American study sought to compare emergency department (ED) visits for acute asthma among women vs men.

The researchers performed a prospective cohort study as part of the Multicenter Asthma Research Collaboration. Patients aged 18 to 54 years, who had presented with acute asthma, underwent a structured interview in the ED and another by telephone two weeks later. The study was performed at 36 EDs in 18 states. Pregnant women with asthma were excluded (n=53). Of 1228 patients, 64.3 per cent were women. Women did not differ significantly from men by age or education level, but women were more likely to be insured, have a primary care provider, and use inhaled corticosteroids. Women had a higher mean ± SD peak expiratory flow rate than men, both early (expressed as percent predicted) (53 per cent ± 21 per cent vs 41 per cent ± 18 per cent; P<.001) and late (77 per cent ± 24 per cent vs 65 per cent ± 21 per cent; P<.001) in the ED stay. Despite this, women were more likely to be admitted to a hospital (multivariate odds ratio, 2.2; 95 per cent confidence interval; 1.3-4.0) than men.

At two week follow-up, women had not experienced more relapse events (odds ratio, 1.1) but were 1.5 times more likely to report an ongoing exacerbation (95 per cent confidence interval; 1.0-2.4).

The researchers suggest that of adults who presented to the ED with acute asthma, women were almost twice as common as men. Although men received less outpatient care and had worse pulmonary function, women were more likely to be admitted to the hospital and to report an ongoing exacerbation at follow-up. Further studies are needed to better understand the complex relationship between sex and acute asthma.


**PATIENTS DO NOT RECEIVE SUFFICIENT ANALGESIA**

This American study sought to compare patient and practitioner assessments of pain associated with commonly performed emergency department procedures and use of anaesthetics before these procedures. It was a prospective, observational, cross-sectional study conducted at a university-based ED with a convenience sample of ED patients. Research assistants recorded the procedure performed and historical and demographic information on standardised data collection instruments. After each procedure, both the patient and practitioner independently recorded assessments of patient pain on a 100-mm visual analog scale (VAS). Use of preprocedure anaesthetics and patient preferences regarding their use were also identified. Categorical variables were analysed by two tests. Correlation coefficients were calculated to assess correlation between patient and practitioner pain scores.

A total of 1,171 procedures were evaluated for the 15 most common procedures performed. The mean patient age was 42.8±18.7 years and 46.1 per cent were male. Overall, the mean patient VAS was 20.8 mm±25.1 mm; the mean practitioner VAS was 23.5 mm±20.3 mm. The mean difference between groups was 3.0 mm (95 per cent confidence interval [CI], 1.3 to 4.1).

Correlation between patient and practitioner pain scores for individual procedures was poor to fair (r=.26 to .68). According to patients, the most painful procedures – in descending order – were nasogastric intubation, abscess drainage, fracture reduction, and urethral catheterisation. Local anaesthetics were administered in 12.8 per cent of procedures yet would be requested before similar future procedures by 17.1 per cent of patients. Patients who would choose local anaesthetics in the future gave higher pain scores than those who would not (43.3 mm versus 16.3 mm; mean difference=27.0 mm, 95 per cent CI, 22.2 to 31.8 mm).

The most painful procedures for ED patients were nasogastric intubation, incision and drainage of abscesses, fracture reduction, and urethral catheterisation. Although practitioners also identified these procedures as most painful, the correlation between patient and practitioner pain assessments in individual patients was highly variable. Overall use of anaesthetics before these procedures was low. Practitioners should be attentive to their patients’ individual anaesthetic needs before performing painful procedures.