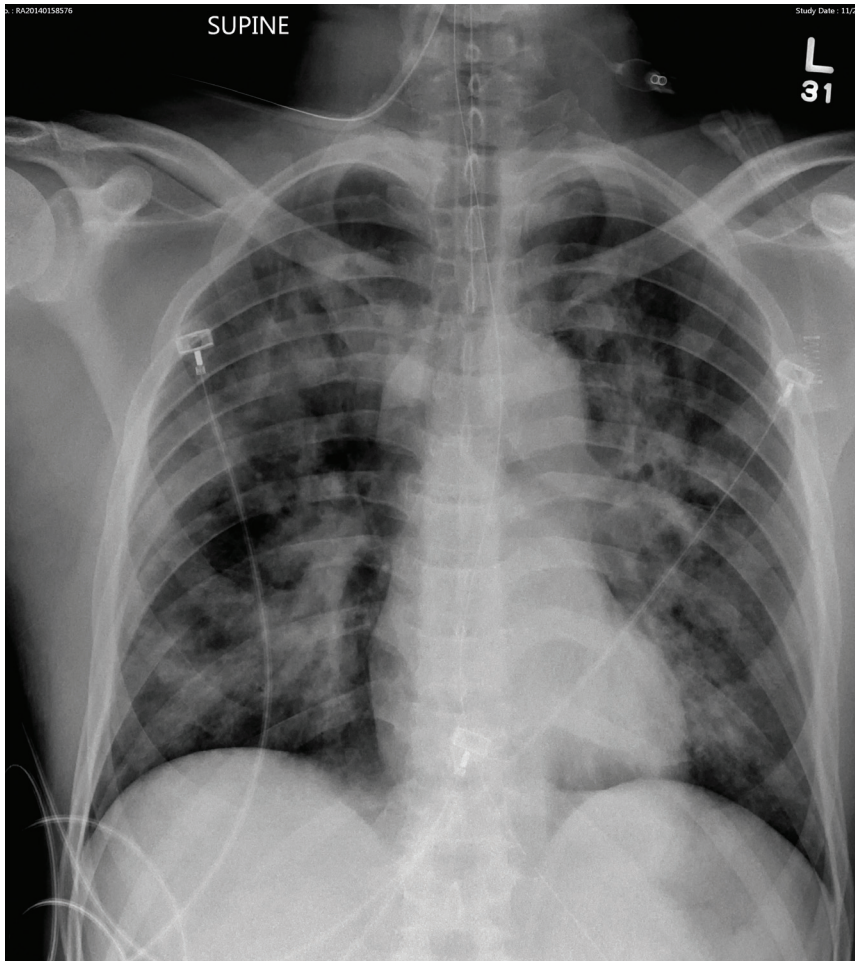
Man Unresponsive After Being Struck by Car



A 50-year-old man is transferred to your facility from an outlying community hospital. He is purportedly a pedestrian who was struck by a car. EMS personnel reported him to be unresponsive at the scene. He was intubated for airway protection and stabilized at the outside facility prior to transfer.

Upon arrival at your facility, he is still intubated and unresponsive, and his Glasgow Coma Scale score is 3T. His heart rate is 150 beats/min and his blood pressure, 105/56 mm Hg. No additional history is available.

Primary survey reveals a large scalp laceration with currently controlled bleeding. His pupils are nonreactive bilaterally. The patient is tachycardic with bilateral crackles. He also has a laceration and deformity of his right lower extremity.

No imaging was provided in the transfer, so you obtain a portable chest radiograph. What is your impression?

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ally, the skin is so damaged that it too must be removed and the toes sewn together.

Removing corns with chemicals, shaving, or excision provides no lasting relief, since these methods do not address the underlying structural issues.

Hard corns, also known as *heloma durum*, tend to develop on the dorsal aspect of the fifth toe secondary to pressure from shoes. Changing the type of shoe worn is one solution, but often, as with soft corns, the underlying bony prominence must be addressed.

There is a third type of corn, the *periungual corn*, which develops on or near the edge of a nail. These corns are often erroneously called warts.

This patient was referred to a podiatrist, who will likely solve the problem. There is no topical product that can help, and nonsurgical approaches will provide temporary relief at best. **CR**

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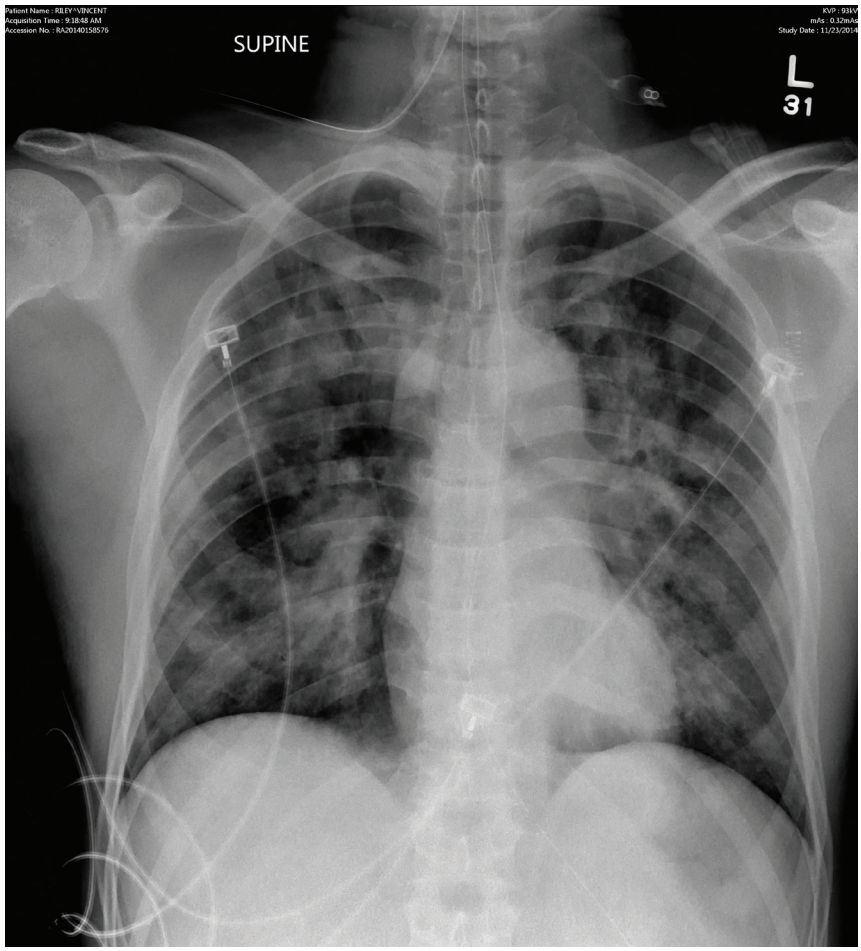

ANSWER

The radiograph demonstrates bilateral patchy, fluffy infiltrates as well as what is sometimes referred to as *ground-glass opacities*. In the setting of trauma and respiratory compromise, these areas are most suggestive of pulmonary contusions and early acute respiratory distress syndrome. Other possibilities in the differential diagnosis include pulmonary edema, atypical pneumonia, and pulmonary metastases. **CR**

sultation and a second opinion in cases involving pain that seems intractable and out of proportion.

One quick word about pain and drug-seeking behavior. Many of us are all too familiar with patients who overstate their symptoms to obtain narcotic pain medications. Will you encounter drug seekers who embellish their level of pain to obtain narcotics? You know the answer to that question.

But it is necessary to take an injured patient's claim of pain as stated. Don't view yourself as "wrong" or "fooled" if patients misstate their level of pain and you respond accordingly. In many cases, there is no way to differentiate between genuine manifestations of pain and gamesmanship. To attempt to do so is dangerous because it may lead you to dismiss a patient with genuine pain for fear of being "fooled." *Don't*. Few situations will irritate a jury more than a patient with genuine pathology who is wrongly considered a "drug seeker." Take patients at face value and act appropriately if substance misuse is later discovered.

In this case, recognition of out-of-control pain may have resulted in an orthopedic consultation. At minimum, that would demonstrate that the patient's pain was taken seriously and the clinicians acted with due concern for her. **—DML** **CR**