studies in four UK ambulance services involved observing clinical work, focus groups with ambulance clinicians, interviews with key stakeholders and analysis of routine data.

Results Baseline survey: 7/13 services were using ePCR, with mixed compliance from staff. Reported benefits concerned improved data access for audit. Of the 6/13 services currently using paper records, four had previously adopted ePCR, but reverted. Case studies: Initial findings suggest some common themes:

- Constant change: 3/4 services were already undertaking or considering transition to a second generation system; 1/4 was undertaking a phased rollout of ePCR.
- Digital diversity: no standard hardware or software in use.
- Indirect input: patient data was still sometimes transferred to the ePCR from another source (eg writing on a glove) or entered retrospectively.
- Data dump: ePCRs acted mainly as a store, rather than transferring information to other care providers or supporting decision making.

Conclusion Although ePCRs offer opportunities to support prehospital care, the transition to the new technology is neither linear nor co-ordinated, with full benefits not yet realised in terms of integration and data sharing.

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CLINICAL PRESENTATION OF PULMONARY EMBOLISM AMONG PATIENTS IN THE EMERGENCY DEPARTMENT

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Aim Pulmonary embolism (PE) is an important clinical entity known to cause a wide range of symptoms. Morbidity and mortality of PE are high. However, knowledge of symptomatology is sparse. Aim: To elucidate the clinical presentation of emergency department (ED) patients diagnosed with PE.

Methods We carried out a cross-sectional study of adult patients attending the EDs at Odense University Hospital and Hospital of Southwest Jutland. The main symptom at presentation was prospectively registered. ED and hospital discharge diagnosis was sampled from the Danish national health registry. Patients with PE were identified based on discharge diagnoses (ICD-10 code I26.0 or I26.9) from the ED or following hospitalisation.

Results Among 24 124 contacts to the EDs, 322 (1.3%) were diagnosed with PE. The main presenting symptom was respiratory distress (31%; n=101), while 26% (n=85) had symptoms

suspicious of heart disease such as dyspnea of cardiac cause, chest pain and palpitation, 8% (n=27) fainting/syncope or suspected neurological disorders, 8% (n=26) pain in the lower limb, and 6% (n=18) had fever as their main symptom.

Conclusion PE patients have a wide variety of symptoms and most PE patients present with other symptoms than dyspnea.

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CAN YOU TRUST ON YOUR PATIENT? – THE ASSOCIATION BETWEEN DEGREE-OF-WORRY VS SELF-RATED HEALTH IN ACUTE ILLNESS

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Aim Self-rated health (SRH) is strongly associated with mortality,¹ and acute hospitalisation in chronic illness.² An association between self-rated health and acute hospitalisation in injury and acute illness has not been shown. The ‘degree-of-worry’-scale (DOW) has been shown to be associated with acute hospitalisation.³ The study aimed to investigate the associations of SRH and DOW on acute hospitalisation in a population of callers to a medical helpline.

Method A prospective cohort study of 11 413 callers to a medical helpline between January 24 to February 9, 2017. Callers were asked to rate their health (1=excellent, 5=poor) and DOW (1=minimum worry, 5=maximum worry) before talking to a call-handler. Primary outcome was hospitalisation within 48 hours after first telephone contact, which was obtained from the National Patient Register. Logistic regression was performed.

Results A total of 11 305 callers with information on SRH and DOW were obtained of which 573 (5.1%) were hospitalised. Age-adjusted odds ratio for being hospitalised with a poor/bad SRH was 2.03 (95% CI: 1.64 to 2.53) and intermediate SRH 1.07 (95% CI: 0.81 to 1.4) compared with a good/excellent SRH. Callers with a high and intermediate DOW had an odds ratio of 4.78 (95% 3.6–6.34) and 2.1 (95% CI: 1.54 to 2.85) compared with a low DOW for hospitalisation. Adjusting for age did not change the estimates.

Conclusion DOW has a stronger association to acute hospitalisation in injury, illness and exacerbation of chronic illness than SRH. Asking about DOW could improve guidance to the dynamic process of decision-making.

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