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Highlights from this issue

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Ah, you're back again then...

If you work in the emergency services you will be aware of frequent users. These are an interesting and diverse group of patients who can account for significant impacts on clinical services. *EMJ* has published a number of papers on the management of such patients and there is increasingly evidence that we can manage them better, but what are they really like? What's the evidence for the attendance reasons behind this often maligned group who we see (by definition) frequently? Vinton *et al* have looked at US databases to characterize and compare infrequent, frequent and super-frequent users (a new term to me), and have found them to be a disadvantaged and vulnerable population with significant disease. This is a reminder to me that our EDs are a safety net for a vulnerable population and that there is much potential to improve the care for these patients through targeted care and management.

'I've come for an X-ray doc'

I'm sure you've heard this opening gambit from many patients in the minor injury queue. It's common to hear patients admit that they come to the ED for a specific intervention or investigation that they feel is required. However, on many occasions as clinicians we may disagree. For example we might decline an X-ray for Ottawa negative ankle sprains. Does this apparent conflict of expectation lead to dissatisfaction? It's a good question as there is an ever increasing focus and use of patient satisfaction scores to assess clinicians. Goodacre and colleagues have examined this interesting question and reassuringly it seems that there is little link between unmet expectation and satisfaction.

Knees or feet

One of the advantages of getting a little older and wiser is that I don't do much

CPR these days. I'm often team leading cardiac arrests so leave the physical stuff to the younger and fitter members of the team. We know that the quality of CPR diminishes rapidly with time but would it degrade less quickly if we knelt rather than stood next to the patient? I've often thought that it would, and that it would avoid the difficulties of different height rescuers coping with a trolley at the same height. Je Oh *et al* have examined CPR performance in the kneeling and sitting positions and found little difference when simulating resuscitation on mannequins.

Predicting cardiac arrest outcome

Kamatsu *et al* in Tokyo have looked at factors that might predict outcome following cardiac arrest amongst 227 patients who survived their initial cardiac arrest. Despite looking at a number of factors commonly believed to be associated with outcome it appears that time to intervention remains the most important factor in achieving good outcomes.

What's the REAL gold standard of a triage score?

Triage scores are designed to sort (obviously) but into what? Typically triage scores are measured against distant outcomes such as death or ICU admission, but arguably they should be evaluated against more proximal outcomes such as the need for intervention. Twomey and Lee have furthered these concepts through the use of an innovative Delphi study using case vignettes to define clinical urgency. This original approach relating triage to acuity is innovative and may have applications in many other areas of emergency practice.

Antibiotics and abscesses

We have a little bit of dogmalysis this month on the use of antibiotics in abscess management. A systematic review by Singer *et al* casts doubt on the routine use of

antibiotics following incision and drainage concluding that the evidence is limited for their use, though there are surprisingly few (589) patients across all trials.

Too tall for a tape?

In Hong Kong Giles Cattermole and colleagues have again found that there are significant difficulties in estimating the weight of children. In this study the Broselow tape was found to be too short for many older children, but that even when too tall they did not reflect adult weight estimates. Like many studies in this area it is clear that simple methods of weight estimation usually fail owing to the variation in height, weight and body habitus in the paediatric population.

Is EM a fixed career?

As someone who came to emergency medicine late following an early surgical career, the paper by Svirko *et al* strikes a chord. EM physicians frequently make their career choice late and show greater variation in career choice as they move through their early clinical years. Whilst other specialties show greater consistency in choice only 27% of EM physicians choosing EM at 5 years post graduation had selected it in year one. The implications for specialty recruitment are complex, where, who and how should we channel our efforts in recruitment?

Apps and AEDs

Finally, a rather clever way of tracking public health resources, for this study Chang *et al* used a mobile app called Gigwalk to identify the locations of AEDs in Philadelphia county. Participants had to find and evidence the location of the devices thereby confirming that they were 'findable'. This novel approach has several potential benefits to routine checks by providers and I think we may see more of this in the future.