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## PREHOSPITAL THROMBOLYSIS: A DEBATE

Every one agrees time to thrombolysis for acute myocardial infarction should be reduced to a minimum. It therefore seems logical that prehospital administration should be a way to achieve this objective. This is certainly a strong message from the UK Department of Health. The evidence for this treatment is reviewed in two papers in this issue. As in any debate, the advocates argue their case from opposing viewpoints to stimulate discussion. However, it seems that we do not have any high level evidence for this intervention, in this population, in this setting. The debate is timely as the National Institute for Clinical Excellence is to issue a consultation on this matter in the near future. Your views are welcome. Please email responses via the journal web site (www.emjoline.com).
**See pages 441, 444**

## FACILITIES FOR CHEMICAL DECONTAMINATION IN A&E DEPARTMENTS IN THE UK ARE INADEQUATE

Rapid intervention is crucial to limit damage by chemicals and poisons. We have audited decontamination premises, equipment, and stocks of specific antidotes to cyanide poisoning in all major A&E departments in the UK. The majority of departments had some equipment for chemical decontamination but there were major inconsistencies in the range of equipment held and these seriously compromised its effectiveness. Only a small minority of departments was equipped to deal with a significant chemical incident.
**See page 453**

## PSYCHOLOGICAL CONSEQUENCES OF INJURY

Improving trauma care should not only tackle physical, but also the psychological consequences of injury. Studies have documented psychological disorder after specific types of injury. Few have examined the incidence of disorders such as anxiety, depression, and post-traumatic stress disorder among A&E populations. This prospective study documents psychological distress among injured A&E department attenders over an 18 month period. A relation between previous psychiatric history and psychological distress was found, but none with injury severity. We found high rates of psychological distress and it is clear that more work is needed to develop this area of trauma recovery particularly in relation to detection and intervention.
**See page 400**

## DO DOCTORS TRUST OVERDOSE PATIENTS WHEN THEY DENY PARACETAMOL INGESTION?

Recent studies have suggested we need not routinely screen overdose patients for paracetamol. We looked at 307 patients on arrival in an emergency department. A total of 155 denied taking paracetamol on direct questioning. Of these, 13 had detectable paracetamol in their blood, although none needed antidote. We also asked practicing emergency doctors, what level of confidence they would require to stop routinely testing. Some 83% require a negative predictive value of >0.1%. This requires a sample of 20 000 patients. We recommend that doctors continue to test for paracetamol in all suspected overdoses.
**See page 408**