

# PRIMARY SURVEY

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## CBRN

Chemical, biological, radiological, and nuclear incidents have risen in importance in the minds of emergency physicians since September 11th 2001. In this issue of the *EMJ* a number of authors have contributed papers that add to our understanding of both the problems such incidents present to us, and the responses we should put in place to cope with the consequences.

Crawford and colleagues have approached the problem of chemical incident response using a Delphi technique in an attempt to poll and collate expert opinion in an area of little primary research. They have used a wide group of stakeholders to reach consensus on the basics of prehospital and hospital responsibilities and actions and report their findings in the first of a pair of papers. Their second paper looks at the implementation of the recommendations and contains a number of practical points for both ambulance and hospital providers. This work has already been used to inform policy in the United Kingdom and many of the recommendations made have begun to become reality.

Kenar and Karayilanoglu have contributed a paper from Turkey that summarises the overall approach to the response to a chemical attack. Readers will be interested to note how similar the approach to such incidents is wherever they occur.

Joanne Ollerton has contributed a review article on the emergency department response to the deliberate release of biological agents. This is a thoroughly

new area of practice and the review is timely and informative. Emergency physicians in temperate climates are particularly challenged by threats from widespread infectious disease incidents as these have all but disappeared from daily practice. The similarities in response to these incidents and to those that arise from new and emerging infections such as SARS will not be lost on readers.

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## MARKERS OF CARDIAC ISCHAEMIA

We have become used to having tests for everything and therefore having the ability to test for anything. As emergency department based rule out myocardial infarction protocols become more widespread the inability to easily test for ischaemia (as compared with infarction) has come into clearer focus. Sinha and colleagues have contributed a study to this edition of the journal that explores the possible role of assays of ischaemia modified albumin in this area. In a thoughtful editorial Sacchetti puts this paper in the context of the development of emergency medicine.

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## NEW WAYS TO LOOK AT THINGS

As new technology develops and is introduced into practice we begin to take it for granted. This may not be a good approach as our familiarity with what we see may obscure the fact that there is more useful information hidden inside the box. Following hard on the heels of a paper in the November edition Leonard *et al* continue to dig into the everyday pulse oximeter and show that wavelet analysis of the waveform has some utility in identifying unwell children. We can only guess at the potential for analysis of other waveforms and their utility in other patient groups and conditions. Watch this space.

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## QUALITY COUNTS

What is quality and how do you measure it? This is a particular problem in emergency departments because the care delivered often contributes to rather than sets the final outcome, and disaggregating this contribution is difficult if not impossible. Beattie reports the outcome of her Clinical Effectiveness Fellowship in this edition of the journal. The Delphi technique has been used to try and reach consensus in a difficult area. This paper is interesting not only because of the measures that reached consensus but also because of those that did not. The lack of true outcome measures (as compared with structure or process measures) is unsurprising, but depressing none the less.

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