Jim Wardrope, *Joint Editor*

ACUTE MEDICINE

The editorial by Dowdle sets the theme for this edition. Acute medicine is an emerging new specialism in the UK, aimed at bridging the gap between the emergency department and the specialist inpatient teams. There is a great deal of overlap between emergency medicine and acute medicine and close, cooperative working is essential. Emergency physicians with dual training in emergency medicine and general internal medicine are being appointed to assist in this cooperation and improve patient care. There is a pressing need to ensure that training opportunities are available for emergency medicine trainees wishing to develop a special interest in acute medicine. The door seems to be opening, but perhaps we need to push a bit harder. Equally acute medicine trainees will benefit greatly from experience in emergency medicine and this is already planned in some acute medicine training rotations.

Many of the educational and professional development needs and research interests of emergency and acute physicians are the same. We hope the *EMJ* can help fulfil some of these requirements. This edition includes a cross section of acute medical issues from deep vein thrombosis diagnosis to the toxicology of wild honey and from thrombolysis to the use of Heliox in chronic lung disease. Whether you practise emergency medicine, acute medicine (or most likely a combination both) we hope you will find the *EMJ* educational, entertaining, and easy to read.

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SARS AND THE EMERGENCY DEPARTMENT

An outbreak of a highly infectious, serious disease has obvious implications for emergency care systems. The paper by Chen *et al* from Taiwan mirrors the experience in other cities hit by the out break of SARS. Total emergency department numbers fell but those patients who did attend were sicker and required more intervention. It is sad that two young doctors died from the disease after treating patients with SARS. This is a risk of practising frontline medicine and a reminder of the threat that infectious disease still poses to society and to all those working in the emergency care system, including ourselves.

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COMMUNITY ACQUIRED PNEUMONIA

Should I admit this patient with pneumonia? This is a common question for the emergency or primary care clinician. Those practising in the UK will be familiar with the existing British Thoracic Society guidelines on this topic. The paper by Campbell *et al* in this edition presents clear diagnostic criteria for the diagnosis and a scoring system to aid decision making. They show that the risks of re-admission or death are low in those scored as being at low risk. As winter approaches in the northern hemisphere it is a good time to review our own practice of this common condition.

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HONEY POISONING

Emergency physicians are usually fascinated by natural toxins, be it box jellyfish or rattlesnake. Honey has a very wholesome image, especially for those brought up on the works of A A Milne. However, the paper from Turkey by Özhan shows this is not always the case. Wild honey is a local traditional treatment for gastrointestinal problems but poisoning attributable to high levels of grayanotoxins is obviously quite common in this area. Those travelling to Turkey on holiday are advised to refrain from raiding wild bees' nests or accepting local cures for abdominal upsets.

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SYSTEMS SOLUTIONS FOR THROMBOLYSIS

Reducing the time to reperfusion treatment for patients with acute myocardial infarction is a key goal for emergency care systems. In the UK, except in a few centres offering percutaneous coronary intervention, this means early thrombolysis. Transport times to hospital, local facilities, and the skill and confidence levels of staff will all be factors in deciding the best way to deliver speedy thrombolysis. Two papers in this edition highlight varying approaches. Corfield shows that delivering thrombolysis in the emergency department can improve door to needle times while Rawles shows how prehospital thrombolysis can start to have an impact in rural areas. The common point in these papers is that they both include all the patients thrombolysed within the whole emergency care system, not just those treated in the part of the system being studied. This is important as selective reporting of results from only one part of the system may lead to bias. A further case report by Price highlights that this treatment is not without its complications.

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GOOD PRIMARY CARE ACCESS CAN REDUCE EMERGENCY DEPARTMENT VISITS

Numbers of patients attending emergency departments continue to increase. The paper by van Uden and colleagues in this edition shows that good access to a primary care centre situated near the emergency department can reduce emergency department attendance, especially out of hours. However, total numbers of out of hours attendances increased. This echoes previous work, the nearer the primary care faculty to the emergency department the more impact it will have on emergency department numbers. Most of the time patients correctly judge the correct type of care they need. However, barriers in access to the most appropriate type of care leads to an emergency department visit.

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Emergency primary care has been a major strength of the UK NHS. However, many emergency medicine physicians in the UK have a sense of foreboding about this winter. Changes to the NHS contacts for primary care physicians mean that they will no longer have an individual responsibility for the delivery of out of hours care. This duty has been given to primary care trusts. Many health communities have plans to deal with this fundamental shift. Those working in the emergency care system hope these plans are robust and well staffed; otherwise this is going to be a long and busy winter.