

## Do we need doctors for the Ottawa ankle rules?

If Blackham *et al* are to be believed, then yes. Their small but clever study shows that when patients in the ED are given the Ottawa ankle rules to use themselves they will always believe that they require an x ray; clinicians, on the other hand, disagree 10% of the time. Reassuringly, if patients cannot manage the relatively simple Ottawa ankle rules on their own then it seems that us clinicians will be needed for some time to come (*see page 750*).

## Nitrous is not enough

Sedation in the ED is controversial, especially so when considering the sedation of children. Despite the increasing use and acceptance of drugs such as ketamine, there are still those who think that emergency physicians should stay away from “anaesthetic” agents and rely on other methods such as inhaled analgesia in the form of nitrous oxide (which, let’s face it, is an anaesthetic agent as well!). Anyway, in this observational study from Melbourne we find the interesting dichotomy of the parents and staff thinking that analgesia is adequate, yet a large proportion of patients clearly report high pain scores. It does therefore seem that nitrous oxide on its own is not enough to provide adequate analgesia and that emergency physicians will have to look to other agents for painful ED procedures (*see page 717*).

## Check the weather forecast before work

Our nurses and docs often chat and guess how busy we are going to be at the beginning of the shift depending on the weather. Maybe it’s because our Manchester climate makes us acutely aware of when it (rarely) stops raining. Sunny days we think of childhood accidents, rain makes us wonder about RTAs and four days of icy pavements predicts a busy day for our orthopaedic colleagues. It seems that there may be something in our musings, as Abe *et al* have shown the influence of meteorological conditions for road accidents. It seems that high temperature, rainfall and holidays are the main

reasons to see an increase in accidents. Well, at least in Manchester we only risk the latter two (*see page 769*)!

## So are SHOs better than F2s?

Armstrong *et al* from Dundee attempt to answer this by looking at the productivity of junior staff in the ED. The measure they have chosen is number of patients seen per hour. It’s an interesting measure and I am sure that you will have your own views on whether it is a good one. You should read the whole paper to decide whether the introduction of F2s has in fact made a difference. On the evidence presented from Dundee there is a difference, but whether it accounts for changes to senior working practice is up for debate ... read it and see what you think (*see page 725*).

## Take a punt on the BETs

This month’s BETs are a mixed bag. It looks as though ultrasound may help us determine intracranial pressure in the resus room—perhaps another key skill for the many budding emergency ultrasonographers out there. Controversially we find that CRP is not a good rule-out test for septic arthritis and that omperazole really does not make a difference in acute GI bleeds, but I’ll BET that many of you (and I) use in practice. Finally, the answer to a real problem in the resus room: when should you perform an emergent caesarian section? I suggest that you read the BET and find out (I’ll give you a clue though—it’s probably more often than you thought) (*see page 764*).

## Pause for PAWS

Early warning scores are increasingly used as an adjunct to triage in the emergency department setting. Simple scores that can identify and track physiological derangement in ED patients have obvious benefits and they have received much attention in adult emergency medicine. For children the situation is somewhat more complex. We all know that children are different from adults (though controversially I’ve always said the similarities outweigh the differences), but to compound matters they come in different ages and sizes as well. Still, such complexities

are merely challenges that can be overcome by sound research. Edgell *et al* have tackled this problem by looking at patients admitted to ICU and comparing them with patients admitted to the general paediatric ward. Using a score devised by themselves, the PAWS score, they quote a sensitivity of 70% and a specificity of 90%. Now is that good enough for our practice, could it be used in practice and is this the right type of study to answer those questions? Clearly you need to read and decide for yourself, though whatever you decide the topic is clearly worthy of thought, debate and continuing study (*see page 745*).

## Do inappropriate patients still exist in ophthalmological specific emergency departments?

Hau *et al* provide an interesting look at patients presenting to Moorfields Eye Hospital in London. The perspective of the study is to see if their patients are “inappropriate” attendees and then to consider how this group can be reduced. I must admit to some concern at that term, as “inappropriate” rather depends on the outlook of the observer as opposed to the perspective of the patient. The authors’ vision seems to be that of a department where the vast majority of patients attending will have acute conditions that require urgent management. Sadly, I think this will be difficult as Moorfields is known to many as a centre of excellence, it is open to all, is in central London and has long opening hours. I have always said that, generally speaking, patients are not daft and they vote with their feet, attending when they feel the need or when no alternatives are available; this is perhaps a case of “build it and they will come” as someone once said. So, the observation that some patients could attend alternative services will surprise few emergency physicians, though this glimpse of our ophthalmological colleagues’ experiences is useful. Fellow clinicians will no doubt have a view on the different pathologies presenting to the eye specific ED as compared to a general ED and will give some insight into what it must be like to work there (*see page 740*).