Primary survey

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The end of the Ice Age?

Will this paper scare or excite the dinosaurs amongst us? Personally, I love papers that challenge established dogma and this month we have a major challenge to a very established therapy. Cryotherapy for soft tissue injuries is standard practice; most of us do it, or at least recommend it, but the evidence seems modest at best. Niamh Collins (***see page 65***) concludes that there is insufficient evidence to recommend routine use. Controversial certainly, but as you look at the cold and frosty weather out the window this month I hope this paper makes you wonder whether the ice is more effective at getting your patients to fall over rather than treating them!

The thaw sets in

If reading about ice is a bit chilly then this thought-provoking article by Lt Col Byers *et al* should warm you up (***see page 108***). The hot zone of a CBRN incident is traditionally a doctor-/paramedic-free zone, but in this well argued article we see that this may deny care to the sickest and most needy. We would not tolerate this in other settings so why should we accept it in a CBRN incident just because it is difficult? Their suggestions for delivering care in the hot zone will not be easy (see figure: proposed "hot zone" treatment plan), but our speciality is pretty good at solving the hard questions. It's good to see yet more dogma challenged.

More on D-dimers

D-dimers, when used correctly, are a great tool for the emergency diagnostician. Regular readers will have followed their progress as a test over the last 10 years or so, and they are now pretty well established as a diagnostic tool. So why more papers you ask? Well, controversy now exists as to how, where and who should be doing them. I imagine that many of you will have been contacted by commercial organisations selling near patient testing kits, and the use of such kits is certainly worthy of study. This month we see that Runyon *et al* (***see page 70***) found that a near patient D-dimer testing kit performed well in a US emergency department. It would be nice to think that this is generalisable to other countries such as the UK, but we must remember that staffing models and turnover may be very different and there are other important implications. Should we return to the days of junior docs performing microscopy on urine, or are there some things that should go the laboratory? How far should the ED go with near patient testing? Let us know your views through the rapid responses.

S100B, again, and again!

As diagnosticians, we at the *EMJ* are always on the look-out for the next useful test that might help us identify patients at serious risk of life-threatening complications. S100B promises much as a theoretically useful marker of acute brain injury, but it has not established itself in practice in the same way that D-dimers have, at least not yet. This month Alastair Pickering *et al* (***see page 88***) show us that it looks unlikely to help in the diagnosis of head-injured children in the ED, a shame as they are a group of patients where a biochemical marker would be very helpful indeed. In contrast, Jana Ambrožič *et al* in Slovenia (***see page 90***) suggest that there is some correlation with S100B levels and conscious level in benzodiazepine overdose, but I am struggling to see how that might help me treat my patient. What do you think? Is S100B a marker looking for an indication or is it the holy grail of brain injury markers?

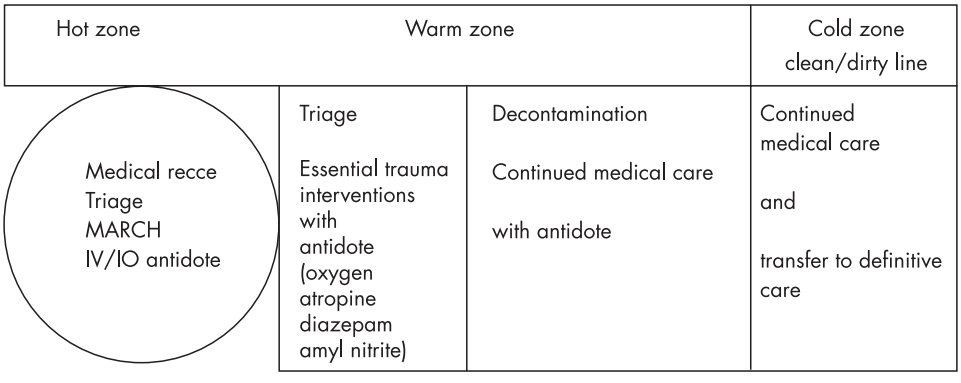

Figure Proposed "Hot Zone" treatment plan. IO, intraoral; IV, intravenous.