

## Nasty about NICE

Alan Leaman's opinion piece about the National Institute for Health and Clinical Excellence (NICE) puts the *Emergency Medicine Journal* in the uncomfortable position of being in the same camp as the *Daily Mail*. However, whereas the popular press attack NICE for their economic judgements, Leaman accepts the need for a body to adjudicate on cost-effectiveness and instead trains his sights upon the guideline development groups. NICE guidelines on chest pain and acute coronary syndrome are forthcoming. Would we be better off ignoring them? *See page 627*

## Ultrasound for intracranial pressure...

Emergency physicians trained in sonography may be interested to read the review by Soldatos and colleagues, which describes the evidence for using optic nerve sonography to assess intracranial pressure in patients with severe brain injury. As usual with new technologies, those left to look after the rest of the patients in the department may be less excited. *See page 630*

## ...and for shoulder dislocation

Blakeley and co-authors outline another potential use for ultrasound. They describe a technique that could be used to augment clinical assessment of shoulder reduction and ensure that patients are not woken from sedation before successful reduction. They emphasise that ultrasound should not replace plain x ray. *See page 662*

## Tachycardia, tachypnoea and fever in children

We all know that tachycardia and tachypnoea may be due to fever but how strong are these relationships and when should we suspect that something else may be going on? Davies and Maconochie

explored the association between fever, heart rate and respiratory rate and found that heart rate increased by about 10 beats per minute for every degree centigrade elevation in temperature. Although there was also an association between fever and respiratory rate, it was not as simple to quantify. *See page 641*

## Good advice for whiplash-associated disorder?

Estimates of the prevalence and aetiology of whiplash-associated disorder are muddied by the high rate of associated litigation. The study by Lamb and co workers suggests that litigation may also be confusing the advice given to patients. Respondents to their survey were reasonably consistent in the verbal advice they offered, with over 80% advising in favour of exercise and against the use of a collar. However, nearly 50% of written material advised how to use a soft collar and 61% contained information from solicitors and about pursuing a personal injury claim. Both may be associated with slower recovery, although causality is uncertain. Do we need to develop written information that supports what we say? *See page 644*

## Communication problems...and solutions

The emergency department is a complex, often chaotic, environment in which communication errors are an ever-present risk to patient safety. In two linked papers, Redfern and colleagues describe the use of the Failure Modes Effects Analysis technique to identify communication problems in the emergency department and then improve the reliability of two steps in the communication process. They end with an appeal to protect some clinical time for system improvement rather than direct patient care. *See pages 653 and 658*

## News from South Africa

Two papers this month provide insights into emergency medicine in South Africa. In the prehospital care section, Stein reports data from out-of-hospital cardiac arrest in Johannesburg (*see page 670*). Of 510 adult cases, 210 were resuscitated and only 36 had a return of spontaneous circulation. It is not clear how many of these patients survived to hospital discharge. The poor outcomes reflect experience from many other parts of the world. Meanwhile, Hodgkinson and Wallis provide a snapshot of case mix in the emergency department (*see page 635*). Almost half the patients were aged between 20 and 40 years old, possibly reflecting a high local prevalence of trauma and AIDS. Children, on the other hand, were under-represented, perhaps due to a nearby tertiary paediatric hospital.

## Teaching basic life support to 14–16-year-olds

Teaching 14–16-year-olds is not the easiest task and the study by Jimenez-Fabrega and colleagues suggests that professional teachers may be better at providing basic life support training than healthcare professionals. A controlled trial showed that immediate satisfactory learning was similar in students taught by teachers alone and those taught by a combination of teachers and healthcare professionals. One year later, a higher proportion of those taught by teachers alone had retained their skills. *See page 648*

## Intravenous self-cannulation

Anyone who has struggled to site a femoral venous cannula will be impressed by the resourcefulness (if not the lifestyle) of the subject of Cooke and Fitzpatrick's case report. He sited a cannula in his own femoral vein, for recreational purposes—presumably without ultrasound guidance. *See page 675*