# Primary survey

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The northern hemisphere has hit high summer and the world is still gripped by World Cup fever. Traditionally, the World Cup is a time when demands on emergency services and attendances at emergency departments (ED) reduce dramatically. Perhaps this will allow *EMJ* readers an early chance to read the journal—there is certainly an interesting variety of articles on offer this month.

## Cocaine and chest pain in London

Unlike almost all other illicit drugs, the (mis)use of cocaine appears to have significantly increased in the UK in recent years. Those working in the front line are only too aware of the adverse cardiovascular effects associated with cocaine use and the fact that cocaine-induced chest pain needs to be treated differently from chest pain resulting from other causes. However, the exact extent of previous cocaine use in patients who present to hospital with chest pain is unknown. Until now, that is! A team from London routinely tested the urine of patients presenting with non-traumatic chest pain for cocaine. Their results are startling and can be found on (***see page 548***).

## ED overcrowding

Patients, clinicians, politicians and the general public can all claim a legitimate interest in the way that patients are managed in the ED. Indeed, there is understandably considerable continuing focus on patient flow rates through ED in hospitals all around the world. Problems with patient flow and the resultant ED overcrowding are often incorrectly interpreted as simply reflecting poorly performing departments, whereas in reality the issue may be access block to hospital beds. Anthony Harris and Anurag Sharma report their experience from Victoria, Australia, in relation to this. They conclude that the availability of fully staffed inpatient beds is a major determinant of ED overcrowding (***see page 508***).

## Rapid access medical clinic

One possible solution to hospital overcrowding and the ensuing overcrowding in the ED is to look to provide alternatives to hospital admission. Data from a rapid access medical clinic embedded within a medical admissions unit in a Scottish district general hospital are presented by Ravi Jamdar and colleagues on (***see page 530***). The success of such a model would appear to depend upon the availability of both sufficient capacity and a senior clinical decision maker.

## Timing of wound closure

An interesting piece of medical history is the subject of a research study from The Netherlands. Following experiments on guinea pigs dating back to the 19th century, it became a widely accepted dogma that patients should not have their skin wounds closed if they present more than 6 h after injury. The reason cited was that late initial closure carries a significant additional risk of infection. Perhaps aware of the relative lack of evidence, or maybe acting instinctively and pragmatically, many practitioners have ignored the dogma and closed wounds presenting after 6 h anyway. A prospective study involving more than 400 patients investigates the scientific basis for the traditional dogma and provides some useful guidance (***see page 540***).

## Digital nerve blocks

More traditional practice is challenged in a multicentre prospective randomised controlled trial from Hampshire, UK. Most practitioners will be familiar with the standard method of achieving fingertip anaesthesia involving the use of two injections of local anaesthetic. However, there are less well known alternatives, including a single injection technique into the subcutaneous tissues on the volar aspect of the base of the digit. The results of the first randomised controlled trial that compares the two techniques might surprise some readers and should help to shape practice—(***see page 533***).

## Unusual cases

A number of interesting but unusual cases are presented this month. If you regularly eat out in restaurants, perhaps you might like to hear about the dangers of the Heimlich manoeuvre. The risks of injury to the victim from receiving the manoeuvre are well documented, but now there are reported risks to the rescuer also (***see page 566***). In a second case, Richard Stevenson reports a patient with amisulpride overdose, in which there was significant QT interval prolongation (a now recognised complication). This did not respond to treatment with intravenous magnesium sulphate, but did appear to respond to the administration of intravenous calcium—the author suggests this as a 'new' treatment (***see page 565***).