

Highlights from this issue

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Geoff Hughes, *Editor*

Canada rules OK

Ottawa and its links with clinical decision rules will be familiar to almost every reader of this journal; if not, where have you been for the last twenty years? This month we publish two papers that have their origins in that fine city. Frank Coffey and local colleagues in Nottingham, in collaboration with Ian Stiell in Ottawa set out to determine the potential of the Canadian Cervical Spine Rule to safely reduce the number of c-spine films performed in a UK emergency department (*see page 873*). Over 24 months and following intense training of 148 doctors their conclusion will be of no surprise to anyone familiar with the rule and with the other rules emanating from Ian Stiell's unit. A pilot study by Canagasabay and colleagues looked at the role of ultrasound in detecting acute ankle and foot bony injuries (*see page 838*). A relatively small number of 110 patients were enrolled; the authors argue that ultrasound shows great promise for the sensitive detection of foot and ankle fractures.

The risk of risk scores

All readers at some time or another will have complained about information overload; once we have had a moan the challenge that faces us is to find a way to exclude the wheat from the chaff and only focus on what we need to. The surfeit of clinical information that we have to wade through derives from several sources but mostly these days come to us digitally. We have to manage protocols, algorithms, guidelines and risk scores, key performance indicators and other audit data.

Kirsty Challen from Sheffield undertook a scoping literature review of outcome prediction for adult non-trauma emergency patients (*see page 827*). Looking through Medline for the years 1950–2009, she reviewed 192 papers that had an

assessment tool that could be applied to a patient at the point of presentation to unscheduled healthcare and with an outcome measure up to 30 days after presentation.

We recommend this fascinating paper to you (ie, why it is the Editor's choice this month) and this editor supports her final recommendation.

Chronic spinal injuries

By the very nature of the work that we do, we are very familiar with and skilled at the assessment and management of patients with acute or suspected acute spinal injuries. Clinicians who work in hospitals that have a spinal injuries unit on site will be better equipped than those who don't in assessing and managing acute medical complications that affect patients with a chronic spinal injury.

Burwood Spinal Unit in New Zealand audited the knowledge (of both ED and spinal unit staff) of autonomic dysreflexia (*see page 866*). Realists will not be surprised to learn that the former were not as good as the latter.

Doctor on board

Readers of a military and/or a prehospital care persuasion will be interested in a paper from the Royal Centre for Defence Medicine in Birmingham (*see page 870*). The authors ask a simple question—what is the optimal skill-mix in military prehospital care, in particular wanting to quantify the medical contribution to the Medical Emergency Response Team-Enhanced?

Their findings are fascinating; a doctor flew on 88% missions; the commonest intervention performed was, not surprisingly, rapid sequence induction. It was thought that a doctor was not needed on 77% of missions; the authors conclude that the indirect benefits of a doctor being involved are difficult to quantify.

Ambulatory intravenous antibiotics

Ambulatory care, the aim of which is to keep patients out of hospital while receiving treatment that historically has been done in hospital, is an ever developing field. Smith and colleagues, from Edinburgh and London, describe the practice of treating children at home with intravenous ceftriaxone (*see page 877*). Median duration of treatment was 2.3 days and was for fever without focus, tonsillitis, peri orbital cellulitis, urinary tract infection and certain categories of petechial rash. There was one failure of treatment (patient admitted for a different antibiotic) and a very high patient satisfaction rate.

Broselow measures up

A team from Cape Town evaluated four paediatric weight estimation methods, to determine which one worked best for them in South African children (*see page 856*). The Broselow tape proved to be the most accurate. The authors offer the sage advice that clinicians must bear in mind that no formula is infallible and constant reassessment and clinical judgement should be used.

Caffeine fix?

Readers who need caffeine while reading this journal should turn to one of our images this month. It demonstrates the coffee bean sign (*see page 826*).

Reflecting on this, the decaffeinated version may perhaps be represented by a legume or a grain. I remember a textbook of physiology (from my student days) describing the kidney as a bean shaped organ and then asking us readers if we should perhaps prefer it the other way round and describe the bean as a kidney shaped organ. It was a small beacon of light on a wet, grey Sunday afternoon of study.