

Highlights from this issue

doi:10.1136/emj.2011.114488

Simon Carley, Associate Editor

There is something of a recreational theme across many of the papers this month. Several address the consequences of sporting mishaps, and several more explore the consequences of recreational drug use. It seems that whatever particular activity our patients choose to live up their day then there may be consequences. Inevitably it is we, as emergency and prehospital clinicians who will be there to pick up the pieces so we should be prepared. This month's journal has plenty of new ideas that will benefit our patients, even the recreationally challenged ones.

Mephedrone

Mephedrone, now a class B drug in the UK, has been widely reported in the media, and not always with the objectivity that we might hope. This month David Wood and colleagues describe the clinical characteristics of Mephedrone toxicity which will help clinicians identify the toxidrome in practice (*see page 280*).

MTB injuries

Aitken and colleagues have looked at the incidence and severity of mountain bike injuries around the Glentress MTB centre in Scotland. In a clever and comprehensive study they have documented the risks associated with a sport that some perceive as dangerous. For those of us who enjoy the sport the overall rate of serious injury was reassuringly low, and finding out that as I get older I am less likely to suffer most injuries apart from a dislocation was reassuring. If you're young keen, male and

aggressive though, it looks less promising for an injury free year (*see page 274*).

IntraNasal Ketamine

INK is IntraNasal Ketamine and it's a great idea from Australia. This case report shows how great clinicians can bring their knowledge, skills and experience from several areas together to help patients. Cliff Reid and his team in Australia used intranasal ketamine in a tricky prehospital care case with great effect and to the patient's benefit. As we increasingly use ketamine and intranasal medications in hospital, (and see increasing recreational use of ketamine) there is logic in bringing them together in the prehospital setting, but having the presence of mind to do this having been flown 120 km, winched from a helicopter and driven 1 km in a 'Ute' is remarkable (*see page 328*).

Suspension trauma

Back in 2007 Lee and Porter wrote in the journal about 'suspension trauma' a condition attributed to the pooling of blood in the extremities when a patient remained unconscious in a harness, during high level work, or again during recreational climbing. At that time they stated that more work was needed and it is a delight to see Adishes, Lee and Porter make good on their word by publishing an evidence based assessment of the literature on the subject. So where are we 4 years down the line? You'll have to read to find out, but the answer is much clearer and will no doubt be of interest to all

those who might treat such injuries (*see page 265*).

Where would you like to be shot?

That's not supposed to be an easy question to answer, but is perhaps interesting to reflect on the conversations you might have had with colleagues when they themselves are ill or injured. When you are in the profession our unwritten knowledge desires and perhaps expects treatment by a consultant skilled in the disease or injury sustained, no junior doctors or trainees for us you might think. So if you are unfortunate enough to be seriously injured then it is sobering to think that your best chance of being managed by trained consultants will be in a war theatre and not back home in your civilian practice. Henning *et al* show us what can be achieved in a well designed trauma system despite the extremely hostile environment of Afghanistan. How many of our NHS hospitals could deliver the expertise and seniority given to patients with major trauma in Afghanistan? I fear that it is very few, and that is something that should ask questions of us all (*see page 310*).

...and are you likely to be shot?

Well possibly, but perhaps not as often as some of the press might think! Tai *et al* show us that even in a major urban conurbation (London) penetrating trauma is still much less common than serious blunt trauma. It's an interesting paper that shows how trauma is changing in the capital and suggests that overall mortality might be reducing (*see page 305*).