

Highlights from this issue

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Establishing a prehospital emergency care service in Pakistan

This paper gives a fascinating insight into the challenges of establishing a quality-conscious government run prehospital emergency service in a developing country. In Punjab none of the major medical educational institutions include emergency medicine as part of their curriculum, and emergency admissions have, in the past, been largely via private vehicles or ambulances with little more equipment than a stretcher and a siren. The authors describe the process of setting up a system from scratch, from the establishment of enabling legislation, to training, and building infrastructure. This process has also had a significant positive impact on the modernisation of other emergency services and provides an excellent example of what can be achieved given the political will (*see page 513*).

Liquid ecstasy

Galicia and colleagues describe the presentation of 505 patients admitted to their emergency department in Spain following GHB (liquid ecstasy) intoxication. They note that more than three-quarters had taken at least one other drug, including alcohol, and that this increases the proportion requiring prolonged admission, ventilation and other interventions, although no patient responded to the administration of either naloxone or flumazenil, questioning the validity of 'blind' administration of antidotes (*see page 462*).

Associations between ED attendance and suicide

This important paper reports that over 40% of patients committing suicide had visited an emergency department in the previous year, and that over a quarter of these were frequent attendees. Da Cruz and colleagues have shown that this latter factor, along with a history of alcohol misuse, is a warning sign of suicide which gives ED staff a valuable opportunity to take preventive measures (*see page 467*).

Health outcomes following ACPO

In recent years a number of clinicians have promoted the benefits of continuous

positive airway pressure and non-invasive positive pressure ventilation in comparison to 'simple' oxygen administration in the management of acute cardiogenic pulmonary oedema (ACPO) in both the emergency department and prehospital settings. Goodacre and colleagues have compared outcome in ACPO patients receiving one of these three interventions, reporting that none confers any benefit with respect to the others in terms of survival or improved health outcomes. Findings such as these underline the importance of undertaking well designed randomised controlled trials before incurring the opportunity costs associated with investing in new equipment and staff training (*see page 477*).

Cold or not?

This short paper reports the lack of any clinically significant discrepancy between temperature recordings made using tympanic thermometers in comparison to bladder and oesophageal probes in patients undergoing mild therapeutic hypothermia post-cardiac arrest in an intensive care unit. Perhaps, however, the authors' conclusion that their findings could be extrapolated to the prehospital setting should be viewed with caution, given other research which reports importance of operator technique in ensuring reproducible and accurate tympanic temperature measurements. As with any clinical measure, education and quality control are vital (*see page 483*).

Time to abandon the GCS?

Not yet—although the paper by Kevric and their team reports higher inter-rater reliability when conscious level was reported using the FOUR score than the GCS. The Full Outline of Unresponsiveness (FOUR) score consists of four components including eye, motor, respiration and brainstem reflexes, and has been developed to compensate for perceived limitations existing with the GCS. However, further research is required to determine the predictive validity of this new assessment tool (*see page 486*).

Palliative care in the ED?

Palliative care is a hot topic in the UK health service and, given the fragmentation

of out-of-hours and community health services, patients with end-of-life care needs inevitably utilise ambulance and emergency department services. This paper reports that between a third and a half of elderly patients dying in the ED could reasonably be defined as having palliative care needs. The majority were admitted by ambulance, many of whom were treated with cardiopulmonary resuscitation which was continued following arrival at hospital. Perhaps not surprisingly, no patient had an advance care plan or implementation of any end-of-life tools, and the preferred place of death was documented for only one case. Although it may be argued that patients with palliative care needs should not be presenting to emergency medical services, it is clear that, when they do so, the treatment plans implemented may not be in accordance with the principle of meeting patients' needs (*see page 491*).

Ketamine and prehospital intubation

Ketamine is increasingly being used in the management of pain and to facilitate sedation to allow managed ventilation in the prehospital setting. This prospective audit evaluated the effects of using ketamine to facilitate intubation, largely by paramedics, in a helicopter emergency medical service. It reports no significant changes in mean arterial pressure and heart rate after administration, both in head injured patients and those with other injury patterns. Although the authors felt that ketamine was an effective drug in the context of facilitation of prehospital intubation, adverse events did occur, including a 7% failed intubation rate and a 7% mortality rate, and there was no attempt to follow patients up to determine long-term survival or neurological outcome. Evidence of benefit from prehospital RSI remains limited. One recent RCT has reported improved neurological outcome at 12 months, but this must be offset against three reviews concluding that there is evidence of no benefit. Even if research shows that an intervention *can* be performed, it doesn't follow that it *should* be performed (*see page 521*).