Highlights from this issue

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Location, location, location?

Five departments in the South West replied to a survey to see if they followed the CEM guidelines about having immediate availability of antidotes to a variety of poisoning agents.

At each of the six chosen sites (one did not take part), questionnaires for junior doctors, seniors and nursing staff were administered, with response rates of 75% (40/53) for senior nurses, 74% for consultants (23/31 with one part-unanswered survey) and 91% (31/34) for middle grade doctors.

The questions asked if they knew were the antidotes were, if not how to get hold of them, and how long it would take to get them (eg, within 1 h, 1–2 or more and if this differed depending on the time of day they were needed).

Results are revealing and should lead the reader to repeat this work in their own department as a worthy exercise! Do you know where the dicobalt edetate or sodium thiosulphate is kept, or how to get hold of more stock?

Is it good to be cold?

Therapeutic hypothermia is recognised in improving outcomes in neonates with hypoxic ischaemic encephalopathy, and for adults with return of spontaneous circulation, ROSC, (though most of these patients had a cardiorespiratory arrest due to ventricular fibrillation or tachycardia). A recent Cochrane study showed that by using cooling blankets or cooling helmets to obtained controlled hypothermia after ROSC, patients were 55% more likely to leave the hospital without significant neurological damage (Cooling the body after cardiac arrest, Cochrane, September, 2012).

The picture in head injury does not show benefit for or against its use, with the matching Cochrane study calling for randomised controlled trial to look at hypothermia in the management of traumatic brain injury.

Given this background, the need to determine the place of controlled hypothermia in the paediatric population with ROSC after cardiorespiratory arrest is of high priority.

This survey, conducted from April to June 2010, showed that there was widespread knowledge of the use of hypothermia, that all departments surveyed had the facility to induced controlled hypothermia but that there were reasons for not doing do, including not being advocated by the local PICU and/or there not being sufficient evidence about its use. There was strong agreement amongst respondents that an RCT of normothermic versus controlled hypothermia was needed in children with ROSC after cardiorespiratory arrest.

Does warfarin cause harm in minor head injury?

This is a retrospective review over 2 years of head injured patients with a CT scan over a 2-year period that found 82 warfarinised patients—12 had with intracranial haemorrhage, of whom 2 did not meet NICE criteria. Have you come across the same scenario? What does this mean for your practice?

What do trainees need for FCEM?

In the UK, FCEM is the final exam for Specialist Trainees in Emergency Medicine, assessing clinical knowledge, attitudes and skills, management principles, critical appraisal, and the ability to search medical literature and synthesise information.

This paper looks at what trainees wanted most to prepare them for this life changing exam.

The results show that practice questions, private study and small group work, plus annual practice were thought to be most useful in getting past this important hurdle, so to continue in the life long learning processes once having got the important FCEM exam.

Evidence guideline for limping children improves their quality of care

Evidence-based guidelines should improve the overall quality of patient care, as the authors state in this paper. They implemented a guideline for the management of the atraumatic limping child and found that there were fewer investigations, more appropriate management focussed to individual patients and a reduced time spent in the ED. Would it be worth seeing if this evidence based guideline could have the same effect where you work?

What is the incidence of major adverse cardiac events in ED chest patients.....

This is an observational study of chest pain adult patients without ECG evidence of ischaemia, low risk according to Thrombolysis in Myocardial Score and low risk biomarker assay at presentation and 4 hour later (at least one test 6 hours from symptom onset).

The negative predictive figures were 99.5% (95% CI 97%-97%) using this system of classifying likelihood of adverse events. The results are certainly worth considering about how able we are to risk stratify such patients, but the authors make clear, prospective validation of these clinical rules is an absolute must before their use.

Massive transfusion protocols

This paper reviews current concepts in massive transfusion policy, the importance of attention to the use of blood and blood products as well as transexamic acid. The clearly delineated easy-to-use protocol is adult based so the reader may want to look at this linkage to recommended dosage of tranexamic acid in children, www.rcpch.ac.uk/child-health/childrens-medicines/childrens-medicines. This recommends the use of 15mg/kg tranexamic acid loading dose (max 1g) over 10 minutes followed by 2mg/kg per hour, to be given within the first 3 hours. Another minor comment is the number of units requested in other Major Trauma Centres is often 6 units of blood and 6 units of FFP initially. This is, however, quibbling about a very useful and informative approach to managing the life threatening condition of massive haemorrhage, and if your department doesn't have one like this then stick it up on your resus wall!