Highlights from this issue

doi:10.1136/emermed-2012-202300

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Triaging pregnant women

Pregnant women presenting to the emergency department (ED) pose specific challenges to the triage nurse. There are many examples of adverse outcomes for pregnant women who have presented to EDs in the UK and Australia due to a lack of understanding of the physiology of pregnancy and a failure to recognise the severity of a problem. These adverse events highlight the need to improve pregnancy descriptors for the triage of pregnant women presenting to EDs. McCarthy and her colleagues (***page 117***), from Melbourne, Australia, want to improve this situation; their study asked one simple question—do condition-specific algorithms and triage education improve triage assessment and documentation of pregnant women presenting to the ED?

Inspector Rebus

A team from Edinburgh describes the experience of one UK training region in establishing an emergency ultrasound training programme and also reports the initial 30 months of scanning experience (***page 112***). The important point in their REBUS study, from a clinical governance perspective, is that there were no adverse patient outcomes. Although we all know that ultrasound is the new stethoscope, I don't think we will ever see the day that young doctors and medical students will walk around the hospital with an ultrasound machine draped around their necks.

Chest pain—again

There are several symptoms that cause chest pain and headaches for emergency clinicians, chest pain and headache being amongst them. The assessment of a patient with chest pain and exclusion of a life threatening disease is a daily occurence for all of us; as you get older this problem seems to get more complex, not because of declining cognitive function but because experience teaches you that no matter how careful you are, some patients can still get through the net and end up being a missed diagnosis with fatal consequences.

This journal has published many articles that analyse and discuss the role of chest pain units, cardiac markers and provocative stress testing, and will doubtless continue to do so for many years to come. A team from Western Australia concludes that serial 2 hourly measurement of four biomarkers alone is not sufficiently sensitive to exclude myocardial infarction. Combined with risk scoring however it does seem to identify patients at lower risk of such an event (***page 149***).

Radiologists versus emergency physicians

Are radiologists better than emergency physicians at reading pelvic trauma plain films? A team from Dorset in the UK and Sydney Australia decided to look into this in some detail; they conclude that their respective abilities to interpret trauma series pelvic are similar (***page 106***). They also comment that if this were also true for chest trauma plain films then the most valuable use of the radiologist may not be in the resuscitation room but in rapid reporting of more complex imaging techniques. However, plain radiography is insensitive for pelvic fracture detection compared with CT, even in expert hands.

The thumb in cardiac compressions in infants

Readers of this journal will know the protocols for adult and paediatric cardiac arrest management like the back of their hands. Such protocols are prescriptive and pedantic; failure to comply precisely can even result in failure to fully complete a life support course. Such pedantry is needed, as in the first few seconds and minutes of a response to a cardiac arrest, we do not want responders procrastinating and vascillating about what to do.

One area where such precision is most marked is in the hand position for performing chest compressions. An interesting manikin study from South Korea compared the overlapping thumb position with the adjacent thumb position; their results may surprise you (***page 139***).

Renal function and acute coronary syndromes

Two teams, one from Pennsylvania and one from North Carolina, asked themselves a simple question—are patients with an elevated creatinine who present to the ED with potential acute coronary syndrome at an increased risk of acute myocardial infarction or 30-day cardiovascular events? Their conclusion appears straightforward; renal dysfunction predicts a higher likelihood of 30-day cardiovascular events, but is not an independent predictor after controlling for other risk factors (***page 101***).

Mild therapeutic hypothermia

At the time of writing this, the UK is experiencing a severe cold snap and many accidental hypothermia cases will be coming through the front doors of hospitals across the nation. The Chinese Cochrane Centre in Chendu, China, has completed a comprehensive literature review about the role and safety of mild therapeutic hypothermia in improving survival and neurological outcome of patients following cardiac arrest (***page 91***). They point out that while it could benefit the comatose survivors of cardiac arrest, therapeutic hypothermia also interferes with numerous physiological and pathological processes, and might have unfavourable effects in patients receiving it and potentially put them at risk for adverse events, such as infection, cardiac dysrhythmia and coagulopathy. Their conclusions are interesting and reassuring.

And...

As usual we have many other interesting articles for you to read; we are sure all readers will find something of interest amongst them.