# Highlights from this issue

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## Talk or test?

Jane McVicar from Liverpool, UK has carried out a fascinating study that compares (patient recalled) immunisation history and immediate point of care testing in establishing the anti-tetanus status of patients with wounds. Consecutive patients with acute wounds aged 18 and over were recruited and questioned about their tetanus immunisation status. They were categorised as covered, not covered or unsure. Each was then tested with the Protetanus kit for tetanus immunity. Interestingly whatever the patient history suggested there was little actual difference in tetanus immunisation status. Dr McVicar went on to undertake a simple economic analysis which suggest that considerable savings might be made using a testing strategy if this replaced current recommended (as opposed to actual) practice—again the results can be seen in the full paper. Well worth a read and a reflection.

## Wrist MR

We have a veritable glut of wrist injury papers this month which is no bad thing as it is a very common presentation to Emergency Departments. The first two of these papers look the management of suspected scaphoid fracture. Nirav Patel and colleagues from the South East of England have undertaken a randomised controlled trial to investigate the cost and clinical effectiveness of immediate MR scanning in this patient group. In short they randomised patients to either have an immediate MR or to undergo standard treatment. They powered their study to detect a 10% difference in cost and also looked at various clinical and social effects at 14 and 42 days. I suspect we all have a view on what the results might show—but to find out what they actually found you'll have to read the paper in full. In a closely related paper Fiona Bowles *et al* from Poole, UK followed up a cohort of patients who had negative scaphoid MR scans at 10 days after injury in order to assess the incidence of continuing symptoms. Of the responders a significant proportion appear to have continuing symptoms at 1 year. This paper is really worth a critical read to see if the (acknowledged) limitations mean that the findings are credible or not.

## Wrist manipulation

Two further papers about wrist injury in this edition of the print journal address safe and effective analgesia during manipulation of distal fractures. In a survey of practice Orthopaedic researchers, led by Harry Sprot, asked Emergency Departments in England and Wales about both anaesthetic and orthopaedic aspects of distal wrist manipulation. The simple, and somewhat disappointing, finding is that half of departments rely on haematoma block with considerable variation in the others. Most commonly the registrars managed the anaesthesia while more junior doctors undertook the manipulation. It is perhaps surprising that there is so much variation in such a common condition. Have a look at the paper for yourself and see if you're surprised too.

In a related paper Nicola Jakeman and co-workers from Bath, UK look at the safety of Bier's Block using lidocaine (a technique that used to be very commonly practiced but which, has been decreasing in use in the UK because of safety concerns). They retrospectively identified a cohort of some 416 patients who had undergone Bire's block using this drug in a little over a 2-year period. Adverse incidents were sought from the medical record. As you will see when you read the paper for yourself there were very few incidents and none that required hospital admission. They conclude that despite guidance to the contrary, lidocaine Bier's block is a safe procedure, and they continue to practice it.

## Track and trigger, trigger and track or triage?

In very topical paper Sarah Wilson and co-workers look at the feasibility of implementation and the potential impact of simple paper-based track and trigger systems in the Emergency Department. The authors looked at the observation sets from 472 patient episodes in their department and assessed the completeness of the data and the accuracy of the calculated early warning score (in the one third of episodes where this had been done). As well as this they studied the patient record to see whether the observations had led to escalation events. In short they found that where warning scores were calculated they were frequently calculated incorrectly. Even more interestingly they found that in the 204 cases where there was evidence of at least one escalation, 163 of these escalations occurred at the time of arrival and were in patients classified as priority one (red) or priority two (orange) by the triage system in use.

While the value of track and trigger systems is pretty well established in ward based care there is a very real debate to be had about their utility in our departments. This paper adds interesting data that suggests physiological triggering is already being done by triage systems at arrival. Is it worth the effort of introducing another system for tracking when many patients are already in high dependency areas and undergoing resuscitation? This paper will contribute to that debate. Read it for yourself and see what you think.

## And finally…

This edition is packed full of other gems: the interesting finding that Swedish EDs are prepared for abused women and children but not abused men, the impact of a dedicated geriatric referral service on admissions in Hong Kong, a proper historians history of the Ambulance Service, a challenging quiz on complex first trimester bleeding and much, much more. Enjoy.