Highlights from this issue

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Richard Body, *Associate Editor*

The burden of alcohol

Anyone who works in an Emergency Department (ED) will know how many attendances seem to be related to the use of alcohol. In this issue, the paper by Parkinson *et al* quantifies the problem, informing us about the proportion of cases that are attributable to alcohol and the most common reasons for alcohol-related attendance. They also estimate the substantial financial cost that this incurs. This fascinating study combined a retrospective chart review of attendances and a prospective evaluation in which breath alcohol concentration was measured in patients attending the ED. The authors found that the peak time for alcohol-related attendances was between 2am and 3am, during which period 59% of patients attending the ED had ingested alcohol. Looking only at attendances on Fridays and Saturdays between 2am and 3am, a staggering 71.9% of all attendances were alcohol-related. One in every six of these patients was admitted to an inpatient ward at a mean cost of £851 per patient, which makes for an expensive night out on the National Health Service. Building on and interpreting those findings, the President of the Royal College of Emergency Medicine asks what we can do to address this problem. In a fascinating commentary, Dr Cliff Mann discusses the potential role of everything from alcohol pricing to licensing hours.

Perimortem caesarean section

There is little doubt that one of the most stressful situations an emergency physician can ever face is to be responsible for treating a heavily pregnant woman in cardiac arrest. Emergency physicians will be fully aware of the need to rapidly proceed to emergent caesarean section, but (given that this is thankfully an extremely rare situation) how many of us are actually prepared to undertake that procedure? Richard Parry provides a comprehensive overview of this procedure including a very practical 25-step 'how to' guide that is likely to be an extremely valuable resource for emergency physicians. Dr Parry goes on to appraise the evidence for this procedure, highlighting the '4 minute rule' to deliver the baby and how the evidence supports the time critical nature of peri-mortem caesarean section as a means of preventing neurological sequelae for the baby. Clearly, minutes matter.

Editor's choice: Can ultrasound confirm central line placement?

Central venous catheter (CVC) placement is another intervention that is often time critical in the ED. Confirming accurate line position can be time consuming, however, when we rely on chest radiographs. This month the Editor's choice is a prospective cohort study from North Carolina in the United States, which compares the use of ultrasound with chest radiography (the reference standard) for confirming CVC placement. Although the number of line misplacements was small (n=4), this study has described a promising technique (the saline flush echo test) that effectively had 75% sensitivity for detecting suboptimal CVC tip placement. Perhaps the greatest advantage of ultrasound over chest radiography was the time taken to test completion, which was a median of 23.8 minutes faster with ultrasound.

Reader's choice: Frequent users of the ED

Perhaps at the other end of the spectrum for 'excitement' in Emergency Medicine, frequent attendees can account for a significant proportion of the ED workload. When patients attend the ED very regularly, it may be tempting to feel reassured and potentially (heaven forbid) even slightly cynical about the nature of their acute complaint. The systematic review by Moe *et al* examined prognosis in this group. Perhaps unsurprisingly for experienced emergency physicians, five out of six studies identified reported that frequent attendees have higher mortality than non-frequent attendees with a median odds ratio of 2.2. Frequent attendees were also more likely to be admitted to hospital and to use outpatient services following their ED attendance. The work highlights the need to take this important and vulnerable group of patients seriously and calls us on to undertake further research that may help to address their adverse prognosis.

Procedural sedation: Patient's choice?

Procedural sedation is a core skill in Emergency Medicine in order to facilitate the undertaking of procedures that may otherwise be unbearably painful for patients. It is tempting to assume that our use of conscious sedation will leave patients blissfully unaware of the procedure afterwards. However, as Dr Gavin Lloyd and Dr Alasdair Gray discuss in a stimulating editorial, this may not be an accurate assumption to make. They discuss a recent report from the Royal College of Anaesthetists and Association of Anaesthetists of Great Britain & Ireland, which recommends avoidance of falsely reassuring terminology when explaining procedural sedation to patients, and they call us on to seek feedback from patients after the procedure in order that we may know how satisfied they were and whether they did, in fact, have any painful recall.

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