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Another fabulous year in Emergency starts with a new world order and new challenges for EM and prehospital care wherever you are in the world. This month our contributors tackle systems, cases, prognosis, analgesia, urine collection and more. Here's the highlights.

Scoring systems and nurses intuition

I've always been told to trust the nurses judgment, and in truth it's got me out of trouble many times, but this intuition, gestalt, judgment is difficult to define. Allan Cameron looked at this whilst comparing nursing views on need for admission against a structured score (the Glasgow admission prediction tool). The bottom line is that nurses don't do as well overall at predicting the need for admission, but if they are sure about their opinion then you'd be courageous (aka foolish) to ignore it. It's good to see more work on how we make decisions in the ED as after that's what can make huge differences to patient outcome.

Critically ill children and medication timings

Kenneth Michelson and colleagues at the Boston Children's hospital have looked at how the presence of really sick patients impacts the care of others. I suppose this is intuitive as we know that the seriously ill or injured suck up the finite resources of the ED, and this study tries to quantify this in terms of medication timings. In essence they have shown that small but significant differences in time to crucial medications (such as antibiotics or steroids) occur if a patient is exposed to the presence of another critically ill child in the ED. It's another lesson that EM requires a team, and that team has a finite capacity.

A wee wait for a wee wee

How I wish this trial was Scottish so that they could have used that title. Alas no, this paper on urine collection is from Adelaide, Australia. If you work in paediatric emergency medicine then you will know that waiting for urine is a common reason for patient delays. Jonathan Kaufman and colleagues looked at a method to augment this by placing a saline soaked gauze in the supra-pubic area in kids aged 1 month – 2 years. They managed a 30% success within 5 minutes, which is impressive although there was no control group and smallish numbers. The effect of temperature is unclear, but they are looking at this and we may learn more in the future.

Predicting exit block

Winter pressures are already being felt in the UK with many departments feeling the pressure of patient numbers and poor flow through the ED. Sue Mason and colleagues have produced a rapid evidence review that may be very helpful in the next few months. Amazingly, despite the huge impact on our departments there is a paucity of data out there on effective interventions and very few from the UK. This paper sets out the evidence base as it exists and we should all familiarize ourselves with it. As for solutions? Then this paper won't deliver that but it is a call for further work (and let's face it we're not short of situations to study here in the UK).

Lis Franc fractures review

Simon Lau and colleagues bring us an update and review on Lis-Franc fractures. This is an injury I've seen missed several times during my career, some of which have resulted in poor patient outcomes. Even with digital radiology and rapid reporting a few seem to slip through the net and so this is a welcome paper. There are some top tips in here, especially for those injuries with limited radiological signs. Well worth a read and a basis of a good teaching session in your department.

Stopping resuscitation in pre-hospital traumatic arrest

When I started training the resuscitation of traumatic cardiac arrest was considered to

Simon Carley, Associate Editor

Highlights from this issue

be akin to resurrection but times have changed and a much more aggressive approach has led to many survivors from blunt and trau-



matic injury. Deciding on futility is tricky and this month we publish a paper from Taiwan that uses a database of cardiac arrest outcomes to determine a rule for terminatint resuscitation efforts. In brief the presence of blunt trauma plus asystole is considered futile. However, we don't know if that is a self fulfilling prophecy. If no efforts are made then a poor outcome is inevitable and a circular argument ensues. Retrospective studies always struggle with this conundrum so have a read and form your own view.

Long term outcome from traumatic cardiac arrest

More on what happens to patients following a traumatic cardiac arrest from our French colleagues. Francois-Xaview Duchateau and fellow researchers examined the Traumabase dataset to look at the neurological outcomes amongst survivors. Overall the results are encouraging and support the aggressive approach to managing these patients. Of note 90% were victims of blunt trauma which makes this month's paper from Taiwan as many of the survivors were in asystole when the EMS teams arrived (which might apparently deem them un-survivable by their proposed tool). Clearly we need to read these two papers in tandem and carefully consider the discussion in this French paper. The bottom line appears to be that we still don't quite understand traumatic cardiac arrest, but that it is not a lost cause. Another superb month in the EMJ.

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