



Highlights from this issue

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Triage and mortality

This is one of a range of studies we have published in the *EMJ* regarding the performance of emergency department (ED) triage scores. In this study, the researchers found that a quick 'eyeball triage' performed better at predicting mortality than the more formalised (and researched) Danish Emergency Priority Tool (DEPT). At first glance, this might suggest that rapid triage by relatively less qualified staff is 'better' than formalised triage, but we need to be cautious, very cautious about such conclusions. When we look at triage tools, we should assess them on what they are designed to do. DEPT was not designed to predict mortality, but rather the need for urgent intervention which is only loosely associated. Whether eyeball triage has a place in our departments remains an interesting question, but first we should define what we want it and its comparators to do.

Juicing, squeezing and returns of redirection

All UK and I suspect that all international emergency physicians will have suffered and been angered by arguments that most patients can be treated in alternative locations. While we all agree that some patients can be redirected, there are disagreements about the proportion and range that can be safely seen elsewhere. It often feels that the redirection bandwagon is led by politically and arguably discriminatory policy. This study is a systematic review of the evidence of redirection policies and, to no great surprise, in my opinion, there is little evidence of any effectiveness. This finding matters as we should be focusing our efforts on strategies that work and/or do support the system. Throwing money at redirection policies that are not evidence-based or shown to be effective is merely a waste of resources.

Alcohol, jail and sobriety

We have an interesting paper this month that once again shows how the ED must link to public health issues. In this US study, the Serial Inebriate Programme was evaluated, a programme that identifies patients with serial arrests for inebriation and then offers them jail time or a rehab programme. The findings are interesting and challenging. The sobriety programme

reduced emergency service use but increased jail time. This rather paradoxical conclusion means that we need to be cautious in simply adopting programmes of rehabilitation without proper analysis.

CBRN decontamination: a primer

I recently attended a superb and rather emotional presentation at the Intensive Care Society on the Salisbury poisonings where nerve agents were used against the civilian population. It was a sobering reminder that we need to be aware and capable of responding to chemical, biological, radiation and nuclear incidents (CBRN). This month we have a must-read review primer article on protocols for casualty decontamination procedures. This is worthy of a read and share with your colleagues, perhaps a simulation and or kit check too. If it can happen in Salisbury, then it can happen wherever you are.

Are we giving enough TXA to trauma patients?

Tranexamic acid (TXA) is now a mainstay of treatment for major trauma patients, or is it? In this study, the Trauma Research Audit Network was interrogated to find out just how many major trauma patients received TXA. At first glance, the authors' findings were that it is a low proportion and it probably is. The study is complex though, as the indication for TXA, i.e. the patient who is bleeding was not directly identified. Instead proxy measures, such as physiological data, were used, which may be the best data we have available. The question of who should get TXA remains unclear. The original data do not support it by giving it to everyone, but are we giving it to enough? Read the paper and see for yourself.

MRSA in the ambulance

There is a short report this month on the potential for ambulance equipment to act as fomites for methicillin-resistant *Staphylococcus aureus* (MRSA) infection. Unsurprisingly, the answer is yes and that is a real concern. What we do not know is what we can effectively do to stop this and how generalisable the findings are. What is of interest is that it is not always the most obvious pieces of equipment that may harbour MRSA, oxygen cylinders for example, which tend to be touched by clinicians rather than the patient.

An approach to syncope in the ED

Matthew Reed is a true expert in the investigation and management of syncope. The *EMJ* has been privileged to publish several of his articles over the years, and we are delighted that he has put his expertise down on paper in this informative and evidence-based review of syncope management. It is a complex area that has caught many of us out in the past (it has caught me out at least), and it is clearly in need of a systematic approach. There are some excellent examples and strategies in this paper and I would strongly recommend a read and share of the advice here.

Variation in subarachnoid bleed workups

We know that clinicians vary, especially when tackling diagnostic conundrums such as suspected subarachnoid haemorrhage. What we do not always understand is why. This is a great paper that takes a qualitative approach to find out why clinicians vary. This is important for all of us as clinician decision-making is a key aspect of variation and overall quality. Perhaps I like this paper because it reinforces my beliefs, for instance, that clinicians involved in what is depicted as shared decision-making may steer the conversation to the a priori beliefs... you know we do this...!

Does ED length of stay affect mortality for our sick patients with sepsis?

I am sure we have all had intensive care unit (ICU) patients board in the ED. Capacity for ICU beds is limited and there will always be times when patients wait in the ED. In this paper from China, the authors have found a link between mortality and time spent in the ED. There are complexities here around the patient mix, but they have tried to control for this and still find an association. The question for us is why this is and whether it can be mitigated. I am a big fan of the 'upstairs care downstairs' concept that states that we should be able to deliver ICU care in the resus room. Whether we can, whether we should and perhaps whether we will continue to have to are all up for debate. I do not think this study proves that ED care is poor, but it does tell us that we need to be vigilant that resuscitation does not stall in the resus room while waiting for an ICU bed.