



Primary survey: Highlights from this issue

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As we make our way into Autumn it's with a sense of trepidation for the Winter ahead. Emergency departments across the globe are facing significant workloads which is challenging for both staff and patients. Under such pressures it's easy to forget about many of the energising aspects of emergency medicine such as teaching, research, and innovation. We really hope that this month's articles remind us all that we can still gain energy from learning more about the fascinating specialty that we work in.

We start with two papers on the care of elderly and frail patients in the emergency department (ED). Most of us are seeing increasing numbers of such patients (something that has been predicted for a long time, but perhaps not as well prepared for as we would wish). Regan *et al* used a qualitative approach using semi structured interview among older people to explore what their experiences of emergency care were. Perhaps unsurprisingly dignity and respect featured strongly in their responses, with concerns raised as to whether the current format and structure of emergency departments can deliver this. The full paper is well worth a read as it will hopefully act as a springboard for us to look at working environments from an older person perspective. In a linked editorial, Dawood and McNamara highlight how this paper and other research highlights how older people are disenfranchised in health settings, including emergency settings. They rightly conclude that we can only achieve supportive and enabling environments for older people if we are willing to engage with them and listen.

The last few years have given me a new-found appreciation of infectious diseases. COVID-19 and now Monkeypox have secured the headlines, but our old enemies are still around us. Some infectious diseases such as syphilis, gonorrhoea and chlamydia are even making comebacks with rising levels of transmission and resistance in some groups and regions. In California Ford *et al* have attempted

to rationalise testing for these diseases using electronic health record based alert systems. It's a relatively simple intervention that prompts clinicians to ask for syphilis testing when other genito-urinary diseases are suspected. This is something that is perhaps one of the more attractive features of electronic record keeping in emergency medicine. This study demonstrated not just an increase in testing but also an increase in positive results which we might hope will lead to better patient outcomes. We've seen similar strategies around HIV testing in other studies and is perhaps another example of why and how emergency medicine can play a key role in public health medicine.

During the COVID-19 pandemic we were delighted to get many offers of help from a variety of sources. While many had little specialist skills some of these were clinicians in training such as medical students. Indeed, in past pandemics such as polio, medical students have made significant contributions to patient outcome. Byrne *et al* have explored this in more depth, completing a systematic review into the willingness and preparation of medical students in relation to disaster medicine. Interestingly they found a significant degree of enthusiasm for volunteering, although this did not always translate into actual volunteering. The authors question whether we really prepare med students for what might be an important role in the future.

Over the years I have noticed a significant variability in the prophylaxis of tetanus. Some of this has been due to changing guidelines, but there is no doubt that a lot of it is due to variation in clinician assessment. This is in part due to the fact that we don't really know who has immunity and who does not, but could we check? This month we have a systematic review of point of care testing for tetanus immunity. This might be an option for us to determine who really does need a booster and/or immunoglobulin. Low *et al* conclude that testing combined with a good immunological history may prove

to be clinically and economically useful in practice. However, there are significant practical factors which may make this difficult in practice.

Orbital cellulitis is a serious condition that we predominantly see in children. Spotting it early when treatment can prevent serious complications such as blindness is important, but often challenging. Tolhurst-Cleaver *et al* have reviewed UK guidelines on the management of this condition and found a significant degree of variability, often with variation between written and verbal accounts of practice. No doubt the variation in guidelines will lead to a variation in practice for what is a potentially blinding condition. Clearly there is work to be done here to get a better consensus to protect patients and clinicians in future.

Smith *et al* conducted a service evaluation study looking at the used of out patient parenteral antibiotic therapy in children. Although this is available in many centres for adults, it is perhaps less commonly used in children despite obvious advantages for children, families and health economies. In this 5 year study 754 children received the therapy for acute infections diagnosed in the emergency department. The approach appears to have worked well with fewer than 14% children subsequently requiring admission to hospital.

Finally, we have another paper from Vassallo *et al* on a comparative analysis of major incident tools in children, an area that I've been interested in for many years. Triage is always complex in children as they come in many shapes and sizes mandating a range of values to be remembered and used in practice. As is usually the case, finding a balance between sensitivity and specificity in triage scores is difficult. No one score came out on top, although the SPTT (Sheffield Paediatric Triage Tool) had the highest sensitivity for life saving interventions. The authors conclude that more work is required including the consideration of using adult scores for simplicity.