# In this issue

**RSI and pretreatment with a competitive neuromuscular blocker**
The LOAD (lignocaine, opiod, atropine, defasciculation) pretreatment sequence for patients undergoing rapid sequence intubation is advocated by the National Emergency Airway Management Course. In this article we look at the evidence for "D"—the administration of a competitive neuromuscular blocking agent for patients with raised intracranial pressure (ICP) due to trauma, to blunt any increase in ICP that may be caused by succinylcholine administration (see page 373). Firstly, we could find no good evidence that succinylcholine caused a rise in ICP in brain injured patients. Secondly the evidence for "D" is based on patients undergoing elective neurosurgery for brain tumours.

**An observational study of emergency department rapid sequence intubation**
Rapid sequence intubation (RSI) is a lifesaving technique commonly used in the emergency management of the critically ill/injured patient. The precise role of emergency physicians in the process of a rapid sequence intubation remains an area of controversy and debate. Considerable variations exist throughout the country in the process of applying this technique to patients in the emergency department. This paper examines the current state of RSI activity in four emergency medicine training programmes in the UK (see page 343). The majority of RSIs were performed for airway protection rather than for hypoxia. The study found that emergency physicians are currently performing RSIs in emergency departments in the UK. The authors recommend that RSI activity in emergency departments should be audited nationally using an agreed audit tool and standards of care should be implemented for the provision of this technique.

**The head injured patient; who cares?**
Inpatient care of head injuries in Britain is in danger of becoming "nobody's baby". Recommendations by the RCSE for surgeons to hand over responsibility to neurosurgeons and accident and emergency specialists prompted a survey of A&E consultants to establish their opinions on the current and future practice of head injury care. Although general surgeons are frequently disinterested in head injury care and neurosurgeons lack the necessary beds, not all A&E consultants are able or willing to take on such responsibility (see page 352). Those who are prepared to accept a new role even for 48 hour care need additional training and resources.

**Burns treatment before transfer**
The early treatment of major burns can be complex. Formula based resuscitation of acute burns injuries is complicated by a lack of consensus regarding choice of initial fluids, with regional variations in practice. There are also practical difficulties in determining the size of the burned area. We have performed a retrospective review of acute major burns to assess the initial clinical management before transfer to a burns centre (see page 349). Several variant approaches were identified, including differences in percentage burn area assessment, application of fluid resuscitation formulas, and transfer documentation. A new treatment proforma has been introduced to provide information on early burns management and to assist documentation.