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Geoff Hughes, *Editor*

Therapeutic hypothermia and out of hospital cardiac arrest

Lyon and his colleagues from the Royal Infirmary of Edinburgh present us with a comprehensive literature review on this subject, with a specific emphasis on the treatment beginning in the prehospital scene or in the ED. Screening a total of 1062 papers for inclusion, their findings can be summarised simply; when it is started as early as is practically feasible, mild therapeutic hypothermia does improve patient outcome, especially in patients whose initial rhythm was ventricular fibrillation.

Many readers may not know that this treatment was first tried 60 years ago. The Edinburgh paper is a first rate review and that is why it is the editor's choice this month (*see page 418*).

Blood products

Staying in the same city and the same hospital, the ED has combined forces with its local transfusion service and has audited its (the ED's) blood usage over a year. They found three particularly interesting results: those who receive blood tend to be elderly, about 50% of requested products are recycled, and about 3% are wasted, both of these latter problems having significant financial implications. Their final recommendation is a salutary, but traditional piece of advice and teaching, namely that care and thought is needed when making transfusion product requests (*see page 439*).

Troponins

The efficacy of troponins in assessing patients with cardiac chest pain is well documented. We have an interesting paper this month from Lille in France. Their study aim was very simple, and that was to see if there is any significance in finding an unexpected rise in cardiac troponins (troponin I) in elderly patients who had

a fall; they studied patients over 65 years of age who presented to their ED after a fall (and being immobilised because of it). As well as, unsurprisingly, being a marker of new cardiac disease, it is a potential marker of stress-induced cardiomyopathy; they also suggest that, more simply, immobilisation on the ground after a fall is in itself a prognostic indicator (*see page 446*).

Patients' perceptions plus providers' profiles

We apologise for the poor alliteration in this subheading. A group of investigators from the USA decided to look at non-clinical characteristics that affect the quality of care in an ED; the results are fascinating but, on reflection, probably not surprising. The providers of care (the staff) felt that patients thought they would get better care from staff with similar demographics, race being more important than gender or religion; female staff were more likely to support patient requests than males. Women, non-white and Muslims were the patient groups most likely to have their requests accommodated.

Such requests from patients, if met, will clearly have an impact on their immediate psychological well-being; if we believe that emergency care can be practised with a holistic approach to the patient experience when possible, then this paper has some important lessons for us all (*see page 465*).

Prehospital care in Iran

In recent years this journal has supported the publication of papers that come from countries with a lower profile in the emergency medicine community than the more traditional "leading edge" countries. Iran is one such country, although it does have a high profile in the world

media for reasons that will not be mentioned here.

This month we publish a prospective study of prehospital care in Tehran, the nation's capital, which led to a significant change in strategy, aiming to fix the problems the study uncovered. The authors of the paper are commendably honest in saying that prehospital care was not as good as it should have been; they cite out-of-date protocols and training courses, a poor national emergency services structure, a poor road fleet of vehicles, a paucity of ambulance stations across the country and public ignorance as contributing factors to the poor results.

They continue by describing the changes being actioned and conclude by saying that an audit will need to be repeated to demonstrate the impact of the reforms and the reform process. It is a paper that will be interesting to many readers (*see page 430*).

Paediatric topical anaesthesia

Finally, for those who have to think about health costs (or should we say 'worry about health costs'), the Starship Hospital in Auckland, New Zealand (the land of the long white cloud), describe the process they followed when they decided to look at the costs (and other implications) of using amethocaine rather than EMLA as the topical anaesthetic agent of choice in its paediatric ED.

The clinical results in themselves are interesting enough; what is also interesting is the details of the model used to complete their financial analysis; if public health budgets are going to be reduced by governments in the months and years to come, then we will see more and more of this type of work being done; in short we will all have to try to get as much value as possible out of the health dollar, pound, euro—or any other currency you wish to select (*see page 456*).