

This month there is something for everybody; new clinical options and reconsideration of old ones, attempts to quantify and assess recent developments, both Political and political, and a challenge to remain at the cutting edge and “move with the times”!

Just because you can doesn't mean you should

Weatherall and colleagues (*see page 144*) describe a laboratory urinary test that could help determine the causative agent, and so, direct antimicrobial therapy in community acquired pneumonia. Recruitment was difficult, the numbers were small, and the authors recognise that the test may be more appropriate on a medical assessment unit. As a result, there is no discussion or suggestion about the place of urinary pneumococcal antigen testing alongside physiological scoring systems or mortality prediction tools in the ED but it does show that Point-of-Care testing is becoming increasingly sophisticated and that we may become more focused and refined in our treatment selection in the future.

Compartments and their pathophysiology

Harrison and colleagues (*see page 128*) provide a fascinating review of a compartment that is often overlooked by those without a surgical background: the abdomen. Previously the domain of the general surgeons and intensivists, the authors show that the physiological principles behind intracranial pressure and the brain apply equally to the abdomen with intra-abdominal pressures and abdominal

perfusion pressures potentially leading to Multi Organ Failure (MOF). They describe how pressure monitoring that is really quite invasive in brain injury, involving drills and skull vaults, is far more easily achieved in the abdomen with merely a urinary catheter, a pressure transducer and a 50ml syringe! Clinical judgement is poor, the diagnosis is often delayed and, they argue, “goal-directed therapy” in this area may reduce the potential for MOF. A different angle on the permissive hypotension debate.

Do ECPs work? (reduce rates of patient attendance at emergency departments?)

The issue of “Treat and Street” or patient non-transport is a governance and risk management hot potato for the ambulance services. A Political imperative to reduce the relentless rise in ED attendance has spawned some interesting initiatives but few have been properly audited or the potential benefit quantified. The Yorkshire Ambulance Service (*see page 168*) present a compelling case that there may be some real mileage in the continued evolution of this group of emergency workers.

Helicopters delay time on scene, shock news!

The chestnut that is the role of air ambulances in an emergency medical service system gets another airing; van Hoving (*see page 136*) describes data from a South African system where there is a significantly longer on-scene time for air transport retrieval than for a land

transport one. Whilst not entirely new, the information supports other published system analyses and shows the magnitude of the difference. There are some significant confounding factors not accommodated, but they do raise an interesting question: are the air medics doing too much for their patients at the scene or are the ground crews doing too little?

Transfusion and trauma

The science behind trauma resuscitation is complex and continues to grow. As discussed in the editorial, the NCEPOD report may have far reaching consequences. One particular aspect of this requiring attention, Westerman and colleagues (*see page 134*) argue, is in the use of blood products, making a strong case for clear national guidance on the appropriate use of a scarce resource, informed by the latest scientific data. Times of war, with British troops currently active in two theatres, are always breeding grounds for step changes in resuscitation science and it is difficult for front-line civilian clinicians to be fully informed on the latest and best. New information is coming on-line all the time and fully informed national guidance would describe the best that we should be offering our patients. Bring it on?

An urban myth no more!

With increasing time served on the shop floor, the tall stories of clinical misdiagnosis come back to bite the unwary. Boos and colleagues (*see page 173*) share one such experience with the ECG, and they have the pictorial evidence to prove it!