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Low speed aortic injuries

I suspect that many readers will associate traumatic aortic rupture with high energy injuries; at least that is what I was told on courses such as ATLS. However, it appears that we might be mistaken, as data from Sastry *et al*, who looked at UK serious car accidents suggest that the majority of these devastating injuries occur in low impact collisions. What does this mean for the general emergency physician? I think it means that we cannot use mechanism of injury information to rule out aortic injury and that the dodgy-looking chest x-ray in the patient following a low speed road traffic accident may be more than just a 'projection problem' (*see page 341*).

A new place to ultrasound?

Judging from the papers submitted to the *EMJ*, emergency ultrasound remains very much in vogue at the moment. Since the initial papers looking at aortic and abdominal scanning we have seen submissions on studies looking at all areas of the body, and I suppose there is an inevitability that we will eventually run out of new body areas to investigate. However, if you are a budding USS researcher do not despair, as the next phase of investigation may be new 'places' to ultrasound. In all seriousness, though, Walcher *et al* have taken FAST scanning to the patient in an interesting study looking at the training and experience of pre-hospital clinicians using ultrasound. It's good to see a paper that looks beyond a short teaching program and actually examines whether participants can effectively use their learning in practice (*see page 345*).

What does sepsis tell us about Emergency Departments?

I must admit to being frustrated and in some way disappointed when reading Lyon *et al*'s paper on the management of sepsis in the ED. They surveyed ED Specialist Registrars (SpRs) to see whether early goal directed therapy (EGDT) can be delivered in Scottish EDs, and the results are concerning. If we agree the EGDT is an important therapy (and I think we can) then less than half of ED SpRs feel able, equipped and in a department that can deliver it. It's worth thinking about what this tells us about sepsis management, our training programs and our trainees. This is clearly something that is within the capabilities of the emergency department so should make us all reflect on whether it can be achieved in our own. While aimed at trainees, as they are often first clinician in attendance, I did wonder what they would have found if they had surveyed the consultants as well (*see page 355*).

An impediment in diagnosis

When asked about diagnostic dilemmas in the resus room, trainees and consultants often choose the assessment of the breathless patient as one that can be challenging. Quite different pathologies can present with a similar clinical picture and I'm sure that many of us have changed our initial diagnoses in these patients with time and investigations. The idea that Thoracic Electro Bioimpedance (TEB) might help us differentiate between cardiac and non-cardiac dyspnoea is very exciting, and in Vorwerk *et al*'s study researchers in Leicester have demonstrated that TEB could change the emergency physician's impression of the

underlying cause in a significant number of patients. The authors do admit that more research is needed, but some technical help in the diagnosis of this difficult group of patients is welcome (*see page 359*).

Glidescope intubations

Emergency airway management is a risky business in the ED and failed intubation is something to be feared. It seems that there have been many new 'devices' to aid ED intubation recently, with various papers looking at fibre-optic and video laryngoscopes. This month we have a paper on the use of the Glidescope, evaluated in a large series by Choi *et al* in Korea. They have used this video technology in 345 intubations and have found it to have limited benefits over standard laryngoscopy, as although the view is improved, the success in intubation is similar. Whether such technologies will catch on is difficult to judge, though the contribution of this large series in real ED patients (as opposed to cadaveric or plastic models) will certainly inform the debate (*see page 380*).

Laryngeal rupture from an airbag

A sad case this month that reflects on a tragic accident affecting a 7-year-old child who suffered a fatal laryngotracheal injury following the deployment of an airbag. The clinical assessment showed barely any external injury, masking the diagnosis until intubation was attempted. This case is a timely reminder that airbags are no substitute for seatbelts, and that the impossible intubation may occur with little warning (*see page 404*).