Highlights from this issue

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Darren Walter, *Deputy Editor*

The editorial instruction for drafting a Primary Survey is to 'create a light-hearted review of the highlights in this edition of the journal'. There are lots of serious messages this time, but there are some entertaining gems that will stick in the memory too!

Get the data

Deasy and colleagues (***see page 411***) report from their VACAR registry in Australia on paediatric hangings and bring some objectivity to a highly emotional and typically anecdotal area of our experience. They give data on outcomes and show that we must simply do more to prevent these catastrophes. A commentary from Pearson in the UK (***see page 371***) discusses how the extreme sensitivity may be concealing the magnitude of the problem. My simple maths gives a rate of one child death per year for each UK NHS hospital catchment area.

Wood *et al* (***see page 387***) highlight the difficulties with emergency attendance coding, in this case with regard to acute drug related attendances to Emergency Departments. They show that demonstrating the extent of the problem is a real challenge; less than half of cases were correctly identified through the ICD10 coding system.

The health 'system'

Lowthian *et al* (***see page 373***) have carried out a systematic review of trends in ED attendance and identify a host of issues. No surprise that the issues are multiple and complex, but the themes that come through are readily recognisable; changing demography, lack of social support, limitations in community care, primary care access, patient convenience and increasing expectations.

Alongside this, Moore *et al* (***see page 422***) report patterns of use by the homeless and factors influencing frequent repeat attendance in Melbourne. Re-attendance rates are high and services feel not to be designed to meet the needs of the patient group. They show that there is a potential 'window of opportunity' to impact on a complex social and health environment and outline some of the areas to consider. How many of our departments could claim to be addressing this group adequately?

Understanding our departments

Estryn-Behar *et al* (***see page 397***) from France outline a frightening rate of burn-out among physicians in their health system and that front-line staff, particularly emergency physicians at 52%, are significantly more affected than average. Team working and getting the work-life balance right will help, but 21% of EM physicians looking at a career change?

Emergency Medicine is a 24 h service and always will be. Our newly arriving staff will have to do night shifts, but during induction do we advise them on how to cope with the lifestyle? Brand *et al* (***see page 446***) highlight that there is official guidance on how to cope with shift work but that we don't follow it. Something else to add to the joining instructions?

Considine *et al* (***see page 416***) analyse the frequency and nature of the adverse incident reports in their Emergency Department. While the analysis is interesting, patient behaviour seems to figure most highly. Those who are older, sicker and who stay in the ED longer have more reports of things going amiss. A significant weakness, recognised by the authors, is reporting bias; clinicians are busy and don't have the time to record every adverse event. They focus on the things where 'official' recording is expected or when there has been a definite impact rather than on everything that should be noted.

And a bit out of hospital

Masterson *et al* (***see page 437***) report on 17 years of experience with out of hospital cardiac arrest (OHCA) in rural Ireland. They are to be commended for their persistence and there are some interesting ideas but there are as many questions generated as answers given. A full Utstein style data template would help for the future. What is the denominator of 'all cardiac arrests'? What is the headline survival rate? What will be the effect of the community resuscitation initiative, the GP defibrillator programme and the enhanced ambulance response? How does timeliness affect the outcomes? The roll out of a national register is to be applauded but a full and comparable dataset will be essential.

At the other end of care spectrum, Lee *et al* (***see page 432***) look for predictors of outcome in patients who have survived to ICU following OHCA. The findings are not a surprise; long periods of initial CPR and significant co-morbidity are a problem, a good blood pressure and improving GCS at 24–48 h are positive signs. Practical clinical indicators that will help decision making in the difficult post-OHCA phase?

All sorts of imaging

Smith *et al* (***see page 378***) report on their experience of adopting a 'Major-Trauma CT' approach to imaging the trauma patient. The evidence for the benefit of a liberal approach to imaging the injured patient, rather than relying on clinical opinion and patchwork scanning, is becoming overwhelming. This excellent observational study makes a strong case for whole torso CT scanning of the trauma patient.

The ED should be able to use all modalities for imaging. Raman *et al* (***see page 450***) show the benefit of Magnetic Resonance Angiography in a case of frostbite and Lin *et al* (***see page 451***) find another use for that ultrasound machine in the corner of Resus!

Finally some memorable cases

There is lots more excellent material in this edition to enjoy, but Fu's 'Walrus Sign' (***see page 450***) will make supervising consultants cringe and Catano's Ventriculo-Rectal Shunt (***see page 452***) shows the power of peristalsis!

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