

## Highlights from this issue

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Mary Dawood, *Editor***Admitting trauma patients to short stay units, which patients are suitable?**

The development of major trauma networks in the UK has increased bed pressures in hospitals that are designated as major trauma centres. However not all patients that are brought to a MTC need admission to a trauma ward, some may just need a few hours observation and support so, it was interesting to read the paper by Michael Dinh *et al* from Australia whose study aimed to derive and validate a prediction rule for short stay admissions. They conducted a retrospective study of all trauma activation patients requiring inpatient admission at a single inner city major trauma centre in Australia between 2007 and 2011. 2593 patients were studied with 30 % being classified as SAAs. Whilst they suggest that further studies are required to prospectively validate the prediction rule this paper will be of interest to those of us already managing trauma patients on SSA's/CDU's.

**FAST scans with added focus**

FAST scans (focused assessment with sonography in trauma) have a key part to play in the rapid assessment of thoraco-abdominal trauma. A study by Smith and Wood in South Africa suggests FAST may also have an added value. This study set out to evaluate FAST's efficacy with respect to patients' haemodynamic stability.

Four emergency medicine physicians trained in emergency ultrasonography who performed the scans and collected the data found haemodynamic instability and a positive FAST result were significantly related ( $p=0.004$ ). This study demonstrated a valuable role for FAST in all traumas, particularly in haemodynamic compromise. So trauma doctors! Is this a new skill to add to your repertoire? Have a read of this paper for the detail and see if you can further enhance your diagnostic capabilities in the trauma setting using FAST.

**Not the speediest solution**

Is air transport of stroke patients faster than ground transport? One might think so and indeed Hesselfeldt *et al* in Copenhagen hypothesized that helicopter transport would reduce system delay to thrombolysis at the regional stroke centre.

They conducted a prospective controlled observational study of 330 patients, 265 with ground transport and 65 with helicopter of which 87(33%) and 22 (34%) received thrombolysis respectively. ( $p=0.88$ ). Surprisingly they found patients transported by ground transport had significantly shorter time from contact to triaging neurologist to arrival in the regional stroke centre than those transported by helicopter. Furthermore, they found no significant differences in modified Rankin Scale at 3 months, or in either 30 day or 1 year mortality between ground and helicopter transport. So in this case, the longest way round may well be the shortest way home.

**A Red herring or a reliable predictor?**

Does atrial fibrillation, irrespective of its timing have a prognostic role in patients with acute pulmonary embolism? This was the question posed by Craveiro Barra *et al* and his team from Portugal when they undertook a retrospective cohort study involving 270 patients admitted with acute PE and followed them for 6 months. They found that the presence of AF, irrespective of its timing, may independently predict mortality in patients with acute PE. However they advised that these data should be tested and validated in prospective studies using larger cohorts.

**Recreation drugs: reducing the burden on the ED?**

Ecstasy and related drugs (ERD's) attendances place a significant burden on already overstretched emergency departments worldwide and these presentations do not appear to be dwindling in any way. The patterns and attendances of such patients may vary from country to country so it was interesting to read a retrospective study by Horyniak *et al* of patients attending two main emergency departments in Melbourne Australia over a two year period. They found that most of the 1347 presentations occurred on weekends between midnight and 6 am; most patients arrived by ambulance, (69%) from public places (42%), private residences (26%) and licensed venues (21%). The authors of this paper suggest that although the majority of these presentations were not serious, the number attending at peak times places

added pressure on the department suggesting that perhaps improved management of minor harms at licensed venues could reduce this burden on ED's. I wonder! but I will leave you, the reader, to decide.

**Pre hospital babies**

There is a sense of wonder and fascination about babies that are born before arrival in hospital and most of the time these events engender a "feel good" factor in the emergency department. Much of the time paramedics will be the first on the scene but there is little in the literature about births before arrival (BBA's) or the important role played by the paramedics. Mc Lelland *et al* in their review of the literature found that most of the actual births attended by paramedics were uncomplicated, nonetheless they all reported either maternal or neonatal complications. These are clinically significant events and the authors rightly conclude that paramedics need to be educated and equipped to manage BBAs safely. They suggest that protocols should be developed between health care providers and ambulance services to minimize risks associated with BBAs.

**Distraction techniques in Paediatrics**

Jedward or Mohawk? Do faces matter? Well apparently they do!

Distractioning distressed children in the emergency department calls for a level of ingenuity and we have all used the inflated glove with varying degrees of success. Eoin Fogarty and colleagues took the glove to another level by designing a prospective study to assess the 'best' way to orientate the glove when drawing a face on it. All children between the ages of 2 and 8 years presenting during the study period were given the option of playing with one of two glove balloons with a face drawn on it in two different ways. 149 children were assessed, of whom 136 picked a glove, 75 picked the 'Jedward' version and 61 the 'Mohawk' version. So a standard hospital glove, inflated as a balloon with a face drawn on it, is a useful distraction for children with an acute injury, but the face drawn should be drawn 'Jedward' style. So to all of you in paediatrics make sure you get the face right or you may have to urgently think of alternative distraction techniques.