Highlights from this issue

doi:10.1136/emermed-2015-205270

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Increasing demand on emergency departments

There is ongoing and often heated debate about the causes of increasing demand on emergency departments. Michael Dinh and colleagues (***see page 708***) from Sydney take a dispassionate look at the data to conclude that (in Sydney at least) increasing demand appears to be driven by the elderly presenting with acute problems requiring inpatient admission. I suspect this conclusion applies to many other health care systems.

But what is the solution? Lijun Fan and colleagues (***see page 738***) reviewed the effectiveness of interventions to reduce emergency department use by the elderly population and found that a number of community-based interventions reduced emergency department use. In contrast, some hospital-based interventions increased subsequent emergency department use. This leaves us in a tricky position. Should we develop services for the increasing number of elderly patients, knowing that this may attract even more attendances, or hope that community-based services will be developed to reduce demand on emergency departments?

Can we prevent burnout in emergency department staff?

Burnout is characterised by loss of enthusiasm for work, reduced empathy and increased cynicism, and a decreased sense that one's work is meaningful, leading to inefficacy. Does this sound familiar? Michael Howlett and colleagues (***see page 722***) explored whether coping style predicts risk of burnout in emergency department staff and found that task-oriented coping was associated with decreased risk of burnout, while emotion-oriented coping was associated with increased risk of burnout. Does this mean that our risk of burnout could be reduced by changing our coping style? There is some evidence that assertiveness training and cognitive behavioural approaches may reduce burnout, but further research is needed to determine whether skills training in task-oriented coping can reduce burnout in emergency department staff. If a simple intervention were shown to be effective then the benefits for staff and the health service could be substantial. Volunteers to participate in this research should form an orderly queue.

No differences in pain relief

Randomised comparison is essential to determine whether one method of pain relief is superior to another. Paul Reavley and colleagues (***see page 685***) compared fascia iliaca block to the '3-in-1' block in a randomised trial of 178 patients with a femoral neck fracture and found no significant difference in pain recorded on a 100 mm visual analogue scale at 60 minutes post procedure (mean score 38mm v 35mm, adjusted difference 3 mm (95% CI −4.7 to 10.8)). Meanwhile, Alison Pywell and Andreas Xyrichis (***see page 733***) found no significant difference between topical amethocaine cream and eutectic mixture of local anaesthetics (EMLA) cream in a meta-analysis of three randomised trials comparing rates of first-time successful cannulation in children (relative risk 1.046, CI 0.975 to 1.122).

Why are we measuring lactate?

Ten years ago I rarely measured a blood lactate level. Now it seems to get measured on every ill patient (and many who are really quite well). But what does it tell us? Can we make a useful diagnosis, prediction or therapeutic decision based on a lactate level? Bernard Foex does a great job of addressing these questions in his linked editorial, while Deepankar Datta (***see page 673***) and Mathilde Pedersen (***see page 678***) with their respective colleagues provide the supporting data. It seems that the question I posed in the subtitle doesn't have a general answer but needs to be asked each time we think about ticking the lactate box on the request form.

Serum bilirubin for appendicitis

I think I remember from my anatomy classes that the gall bladder and appendix are on the right side of the abdomen somewhere but not right next to each other, so measuring bilirubin does not seem like an obvious way of diagnosing appendicitis. However, studies have suggested some value so Sven Muller and colleagues (***see page 698***) set out to test it in a cohort of 493 patients undergoing appendectomy. There was an association between appendicitis and bilirubin elevation but probably not enough to be diagnostically useful. The positive and negative likelihood ratios of elevated bilirubin for diagnosing appendicitis were 2.62 (95% CI 1.65 to 4.16) and 0.75 (95% CI 0.67 to 0.83) respectively. Interestingly, white cell count and C-reactive protein were more sensitive and less specific than bilirubin at the thresholds tested but overall were probably no more diagnostically useful.

Keep it simple stupid

And finally, introducing us to mind maps, Ian Higginson (***see page 750***) reminds us of the principle behind Ockham's (or Occam's) razor – don't complicate unless you have to. This may be worth remembering before you order a blood lactate or bilirubin.

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