



Highlights from this issue

doi:10.1136/emered-2018-208181

Richard Body, *Deputy Editor***It's getting cold out there**

In this issue of the journal, you will note that we have a special focus on accidental hypothermia. In fact, we have no less than four articles covering this issue: two original articles and two commentaries. Freeman *et al* focus on the pre-hospital management of accidental hypothermia and report the results of a national survey of practice for preventing and managing accidental hypothermia among pre-hospital retrieval services (*see page 652*). Having approached ground ambulance, air ambulance, mountain rescue, lowland rescue, cave rescue and lifeboat and life-guard organisations, they identify substantial variation in practice with regards to packaging, temperature monitoring and the management of accidental hypothermia in this context. In the accompanying commentary (*see page 657*), Dr Gordon suggests that the voluntary status of many of these search and rescue organisations may have prevented them from having robust evidence-based protocols. Dr Gordon goes on to suggest that this may be a 'wake up call' for such services, demonstrating the need to harmonise clinical protocols for this important condition.

In a separate piece of research, Mutsuyama *et al* report research that provides valuable insights into the epidemiology of accidental hypothermia (*see page 659*). After creating a registry and collecting data for 5 years, they found that the vast majority of accidental hypothermia occurs in the elderly and in an indoor setting. Most emergency physicians will be aware of the prognostic significance of

accidental hypothermia in the context of trauma. This work goes further and shows that the mortality rate of accidental hypothermia is extremely high (almost 25%) regardless of the aetiology.

Traumatic cardiac arrest in children

In recent years there has been growing recognition that traumatic cardiac arrest occurring in adults requires a different approach to non-traumatic cardiac arrest. However, gathering sufficient evidence to justify a change of approach in children is extremely challenging, partly due to the small number of children affected. In this issue of the journal, Vassallo *et al* address this problem by producing a consensus-based guideline for the approach to paediatric traumatic cardiac arrest (*see page 669*). The team has addressed many topical and important questions. Are chest compressions important? What is the role for thoracotomy in both blunt and penetrating trauma? Should pelvic binders be routinely applied? And when should resuscitation attempts be stopped? The consensus guideline addresses all of these questions and is therefore a very important piece for all those practising in Paediatric Emergency Medicine.

What is a 'significant illness' in a child?

Paediatric early warning scores are also increasingly topical in Emergency Medicine. There is great interest in the use of prediction models to identify those children who have serious illnesses at the

earliest possible opportunity. A particular challenge for research evaluating paediatric early warning scores is knowing exactly what they should be able to predict. 'Significant illness' is a heterogeneous term, which is difficult to define. In this issue, Lillitos *et al* also take a consensus-based approach to define significant illness in paediatrics (*see page 685*). Having done so, this work will be of great value for future research evaluating paediatric early warning scores.

How much time to emergency physicians spend with patients?

I'm sure that many emergency physicians will, like me, believe that they spend too much time undertaking tasks that do not involve direct contact with patients. There are so many other tasks to complete: communication with other team members, waiting to contact inpatient teams; filling out forms; requesting investigations, etc, etc. In this issue, Dr Abdulwahid *et al* report the results of a systematic review of time and motion studies that have evaluated exactly how long emergency physicians do spend in face to face contact with patients (*see page 692*). Their findings may not surprise us: the majority of our time is spent doing tasks other than seeing patients, and senior emergency physicians are busy, undertaking many different tasks per hour. This work is important, however, as it quantifies the amount of time we do spend with patients. This is important for workforce planning and to better understand patient flow in the modern era.

