Highlights from the issue

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Happy 50th birthday, UK Emergency Medicine

As we saw out 2017 we also celebrated the 50th anniversary of Emergency Medicine (EM) in the United Kingdom. This special commemorative issue of the journal celebrates the momentous occasion with a number of pieces to reflect on the history of the specialty and to look forward to its future. In another 50 years, emergency physicians will undoubtedly look back at this issue of the journal as a key reference to the state of EM in 2018. It is without doubt, therefore, a must read for all emergency physicians.

How did we get here?

The issue includes some fascinating reports on the history of UK EM. As we begin to see a glimmer of light appearing towards the end of what has been the bleakest of winters for our specialty, we think back to a time when the challenges, though still great, were of a very different nature. Jonathan Marrow reflects on his 50 year career. He recalls how the number of consultants in EM at the departments in which he has worked has increased from zero to twelve, now achieving close to 24 hours resident coverage. How times have changed. David Yates, the first Professor of EM in this country, gives an invaluable narrative of the history of EM. He discusses the contribution of such household names as Maurice Ellis, John Wiegenstein, Herman Delooz and Humpty Dumpty. Yes, you read that right. You'll have to read this intriguing piece to discover the connection!

As if that wasn't enough, we reflect on the landmark papers published in our specialty over the last 50 years; the growth of Pre-hospital Emergency Medicine; and our increasing connection with emergency nursing. Be sure to digest it all: this is truly an historic issue of the Emergency Medicine Journal.

Where are we heading?

As well as looking back at the previous 50 years, this issue also shines the spotlight on our direction of travel. Taj Hassan, President of the Royal College of Emergency Medicine, asks how we will face up to some of our greatest challenges including exit block and career sustainability. He discusses the future role of research, training and education. Alasdair Grey and David Yates discuss the future of EM research; Will Townend and colleagues address the future of EM education; while Simon Carley and Simon Laing discuss how technology will shape both our future clinical practice and the way we learn.

OK Google, call the doctor

While we have appropriately devoted substantial attention to the 50th anniversary of EM, this special issue is also rich in original research. Most of us have probably only ever really considered telephone interactive voice response systems (IVRS) as tools for randomising patients to clinical trials. However, Calder *et al* have evaluated the use of IVRS technology to automatically follow-up patients after ED attendance, and to book nurse consultations for those with persisting clinical concerns. This is a fascinating new use of technology, and perhaps something we're likely to see more and more of. Could the likes of Google Home and Alexa soon be assisting with our healthcare?

Getting the most out of troponin

Hopefully, in part 1 of our series on cardiac troponins, Edd Carlton and I may have managed to play a small part in alleviating 'troponinitis' (or the over-diagnosis of acute myocardial infarction, AMI) in your Emergency Department (ED). Part 2 of that series appears in this issue, in which Edd and I provide a simple overview and review of the many early 'rule out' strategies that could help to reduce unnecessary hospital admissions. Do you know the evidence for your own ED's chest pain pathway? Have you considered the alternatives? This narrative review should help to bring that evidence to your fingertips, and we hope it will help you to interpret it in a practical way.

Building on that theme, Jaimi Greenslade and colleagues have analysed the differences in clinical presentation between type 1 and type 2 AMI. Can clinical features differentiate between the two? You may be surprised.

Paracetamol: intravenous must be better than oral, right?

Here's a very common scenario in the ED. You administer intravenous opiates to a patient with moderate or severe pain but some pain persists. Prescribing additional paracetamol may help to reduce overall opiate use, and you may instinctively believe that intravenous administration is likely to be more potent than oral. Furyk *et al* have studied exactly that issue, in a randomised controlled trial. You may be surprised to read the results, but they make important reading for every emergency physician.

Blood and calcium

We also delve into the field of major trauma in this issue. Kyle *et al* studied ionised calcium levels in injured soldiers who received pre-hospital blood transfusions. The findings lead the authors to question whether intravenous calcium should be given to every patient undergoing blood transfusion following major trauma, and even whether this should be given in the pre-hospital environment. This would be quite a paradigm shift. You should read and appraise the article yourself, and decide whether you're convinced.