



# Highlights from this issue

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## Prehospital intubation and the checklist – what can we learn

Prehospital anaesthesia, PHEA (or rapid sequence intubation) is performed in many systems, often by physician-led teams, or specially trained paramedics. As with many high-risk procedures, it is recommended that clinicians performing these procedures follow a standardised checklist. In this month's issue, our Editor's Choice is an eye-opening survey by Burgess and colleagues that included 43 of the 59 physician-led prehospital teams in the UK, determining the volume of intubations and the use and format of their prehospital intubation checklists (*see page 532*). They logged 1629 intubations and it is worth noting that of the 34 services who performed these, 10 performed 84%. Checklists were used among 83% of services, and 20% had a standard operating procedure. Reviewing 24 of these checklists, the authors found a mean of 41 (28-70) required checks, and that the style, and complexity ranged from simple phrases to full sentences. In his commentary on this paper (*see page 530*), Stephen Hearn, Consultant in Emergency Medicine and lead consultant for Scotland's Emergency Medical Retrieval Service points out how few checklists we actually use in our emergency departments, and where we might benefit from developing some. But he also warns: 'To be effective and accepted these checklists however need to be carefully designed and trialled before their introduction.'

## Passive leg raise in healthy volunteers – a new wrinkle

It is suggested that one can assess preload responsiveness at the bedside based on a patient's response to passive leg raise. Elwan *et al* (*see page 544*) studied 50 healthy adult volunteers to examine the normal haemodynamic response to passive leg raise using stroke volume increase of >10% as a sign of fluid responsiveness. Patients underwent two trials of passive leg raise. Half of the patients were fluid responsive and the agreement between the two trials in the same person was good (Cohen K=0.68). Patients who were older and had lower stroke volume at baseline were more likely to be fluid responsive.

The study showed that PLR is reasonable method of assessing fluid responsiveness, with good reliability between measurements. However, the authors note, if half of healthy volunteers are fluid responsive using PLR, how should we interpret this measurement in emergency care.

## Why are my ultrasoundguided IV's failing?

And while we are on the subject of fluids, what about the patient who requires intravenous antibiotics or fluids, but you cannot establish intravenous access. More and more in non-resuscitation situations, physicians are turning to ultrasound-guided access. Unfortunately, and as I can personally attest to, these IV's seem to fail at a disappointing and frustrating rate. Pandurangadu *et al* (*see page 550*) have done a clever study to determine what variables predict failure of an ultrasound-guided IV during the subsequent 72 hours. Overall, failure rate was 34% which is probably no surprise. Length and gauge of the cannula, history of poor IV access or renal failure, were not found to be significantly associated with IV failure, although some of these analyses may be limited by small numbers. However, the greater proportion of the catheter in the vein, the more likely the catheter was to survive for 72 hours. At 65%, no IV's failed.

## I don't know much about (body) art, but I know who I like

Over the decades, patients have been asked for their preferences about physician attire. Some of these studies have shown patients pictures of physicians and asked them to rate their professionalism, knowledge and perception of competence of the person they were looking at. In general, the results of the studies are predictable: patients say they would prefer the professionally dressed physician. Also using photographs, patients found tattoos among nurses less desirable. However, times are changing and body art in physicians and nurses is now common; furthermore, none of the prior studies examined how patients actually rate their interactions with providers sporting a non-traditional appearance. At an emergency

medicine residency training programme in Bethlehem Pennsylvania, Cohen *et al* (*see page 538*) conducted a clever self-controlled study: residents worked some shifts wearing body art (either their own, or fake tattoos and piercing) and other shifts as themselves (or hiding their own body art). Patients they treated were asked to complete a questionnaire assessing competence, professionalism, caring, approachability, trustworthiness and reliability.

The result: The residents received top scores regardless of their appearance. Worth noting is that the study was not conducted in a major cosmopolitan city like San Francisco, New York or Los Angeles. However, many factors such as wait times were not taken into account and there was little ethnic or racial diversity among the residents. Nevertheless, this study's findings remind us that physician-patient relationships are more than skin deep, and that opinions are not a substitute for experience.

## And did you do a rectal exam?

This month's review is actually a debate on the question of whether the rectal exam should be a required part of the exam for evaluation of the acute abdomen (*see page 579*). Every medical student is taught that the rectal exam is an integral part of the abdominal exam, but is it still true? Although perhaps not the most critical issue in emergency medicine, the rectal exam is uncomfortable for both patients and physicians and the question of what it yields and whether it needs to be done comes up daily in practice. Is the rectal exam sacrosanct? Osama Elhardello and John McFie, surgeons from Scarborough General Hospital and Mansoor Khan, a surgeon from St. Mary's Hospital go head to head on the value of the rectal exam in modern-day medicine. Whose side will you choose?

