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**Is it OK to close emergency departments?**

Many emergency physicians would be very concerned by any talk about closing Emergency Departments (EDs). We may have experienced it in our own regions, and we may have our own opinions about its impact on patient care. In this issue, Knowles *et al* have studied the real-world impact of closing five EDs in England on patient mortality. Read the full paper for details, but the bottom line is that they found no impact on patient mortality. Does this mean that the government should have the green light to close more EDs? Or is there more to the story than this? To read more about this very important topic for emergency physicians, make sure you not only consult with the original research article by Knowles *et al* but also the associated commentary by Dr Cliff Mann, the National Clinical Advisor for A&E (Emergency Medicine) at NHS England.

**Basic life support on the X-box?**

What makes training in cardiopulmonary resuscitation (CPR) most effective? In this issue, Otero-Agra *et al* evaluate several techniques for maximising the effectiveness of CPR training in school children, including gamification. They found that gamifying the process was more effective than standard training methods. So where next for basic life support training? Meanwhile, Becker *et al* have studied public perceptions about performing bystander CPR. The people they asked expressed various concerns and barriers to performing bystander CPR. This has important implications for pre-hospital cardiac arrest care. But would they have answered differently if their training had been gamified?

**Is blunt traumatic cardiac arrest in the elderly survivable?**

For some time, it was believed that outcomes of patients with cardiac arrest following blunt trauma were dismal. There is now evidence to suggest that outcomes may be better than perhaps we once appreciated. However, it might seem reasonable to speculate that the outcome of elderly patients who sustain a cardiac arrest after blunt trauma may be particularly poor. Norii *et al* set out to evaluate whether attempted resuscitation is futile in this group, using data from a large national Japanese registry. The results may surprise you: outcomes are possibly nowhere near as bleak as you might imagine. Check out the paper for the full details – and to find out which, if any, interventions were associated with survival.

**HEMS and paediatric airway management**

There have been some landmark trials evaluating pre-hospital advanced airway management recently. For adults in cardiac arrest, there's now some strong evidence to suggest that advanced airway management doesn't improve patient outcomes. We don't have as much data, however, in children. There are probably few things more challenging than being faced with a child who apparently requires endotracheal intubation in the pre-hospital environment. Garner *et al* report the results of a retrospective study in Sydney, evaluating outcomes in children who required pre-hospital advanced airway management over a five and a half year period. The question they asked was whether Hospital Emergency Medical Services (HEMS) would achieve greater success and fewer complications than Ground Emergency Medical Services (GEMS). Most of us are attracted to the idea of using HEMS to improve patient outcomes. But did that translate into better outcomes of pre-hospital paediatric intubation? And, if it did,

would that convince you of the benefits of HEMS? Check out the full paper to make up your mind.

**Measuring quality in musculoskeletal trauma care**

Measuring the quality of care that we provide in the ED is clearly important. A key challenge, however, is to identify a reasonable set of goals to aspire to when managing any one patient group. In this issue, Strudwick *et al* have set out to develop a series of quality indicators to determine what high quality care should look like for patients with musculoskeletal injuries. After taking an elaborate mixed methods approach, the authors have arrived at a list of 36 metrics. How do you scrub up against those standards? How might the clinicians in your department perform? And might you now be able to use these quality indicators to audit the quality of care in your department?

**Bleeding haemodialysis access sites**

If you work in a specialist nephrology centre, as I do, you may be no stranger to ED presentations relating to complications of haemodialysis. A bleeding haemodialysis access site can be challenging to manage for emergency physicians. Our gut instinct to compress the site could lead to thrombosis. In this issue of the journal, Saccheti *et al* present a case series in which vascular closure buttons were successfully used to control such bleeding. I know that you're already starting to turn this page, believing that this is not relevant to emergency physicians. But wait. All of the cases presented were managed by emergency physicians, without assistance from nephrologists or vascular surgeons. Could this be a new core skill for emergency physicians?

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