Highlights from this issue

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Editor's Choice

Emergency physicians are duly proud of their ability to perform life-saving procedures. But opportunities to use some of our most critical skills can be infrequent, potentially resulting in a loss of skills. We present two studies addressing how often we need a refresher, with somewhat disparate conclusions. Our Editor's Choice is a randomised study of training on a mechanical CPR device conducted by Coggins *et al.* After initial training and baseline assessment on the LUCAS-3 device, the intervention group received a refresher at 4 months, while the control group did not. All participants were retested 6 months after initial training. The intervention group was faster in starting CPR with the device and made fewer errors, suggesting that there is already significant forgetting at 6 months without a refresher in the interim. In contrast, Craig *et al.* surveyed 1332 paediatric emergency medicine specialists at 96 EDs worldwide, asking how often they thought they needed to retrain on 18 particular skills. There was a great deal of variability in the recommendations, ranging from 1 month to 1 year. Bag-valve mask ventilation, CPR and endotracheal intubation were recommended for 3-monthly or 6-monthly practice by 63%–65% of respondents, with the rest suggesting 1 year. We invited a commentary by Dr Ruth Brown, a leading educator in the UK, to help reconcile these findings.

A timely refresher on measles

Dr David Jordan, an ichthyologist at Stanford University, was renowned for his encyclopaedic knowledge of fish. But he had trouble learning his student's names, and finally he gave up trying, saying 'every time I learned the name of a student, I forgot the name of a fish'. So, now that you've acquired new knowledge in your career, what do you remember about measles? In 2000, the USA proclaimed that measles had been eradicated from the country. Yet an epidemic of measles, largely blamed on 'anti-vaxxers', recently erupted in the northwest of the USA and continues to work its way down the west coast. The USA is not alone; worldwide, 2018 saw the largest number of measles cases over the past decade, with the number of cases in Europe tripling from the

prior year. Measles in the UK rose jumped threefold from 259 lab-confirmed cases in 2017 to 913 in 2018. Will you recognise measles and know how to handle treatment and prevent transmission to your other ED patients? Be sure to read our review on measles.

Something old, something new...

Immune checkpoint inhibitors, recently and increasingly used for treatment of a variety of cancers, hold substantial promise, but present new challenges to emergency physicians. Toxicity from immune checkpoint inhibitors (immune-related adverse events [IRAEs]) may look like other diseases and patients may not know (or physicians may not ask) what drugs they are being treated with. A study by Peyrony *et al.* found that, of 409 patients being treated with immune checkpoint inhibitors at their institution in Paris between 2012 and 2017, one-third presented to the ED and 14.4% of these visits were due to IRAEs. Based on chart review, physicians identified only half of these as an IRAE and only considered it in 17% of these patients. The article will be particularly valuable to clinicians as it also evaluated risk factors for having an IRAE and provides a spot-on table of common IRAE symptoms and signs.

Triage Sort

A study with wide-reaching implications questions current triage procedures in a mass casualty incident. Standard practice in the UK and elsewhere is two-stage triage, with primary triage at the scene followed by a more detailed assessment—the Triage Sort. The value of this secondary assessment has not been studied in a civilian population. Using data for 127 233 patients entered into the TARN database between 2006 and 2014, Vassallo and Smith compared the performance of Triage Sort, National Ambulance Resilience Unit Sieve and the Modified Physiological Triage Tool-24 for ability to identify patients who went on to receive life-saving interventions. Triage Sort had the highest undertriage rate (84%) but the greatest specificity, with the authors concluding the role and mode of secondary triage needs to be reviewed.

NEWS for all?

The Royal College of Physicians has recommended that the National Early Warning Score (NEWS) be applied in outpatient settings. But in a generally well population, NEWS could result in some false positives, identifying patients who are not sick yet score high. To address this concern, Scott *et al.* studied the distributions of NEWS score after it was rolled out to the entire healthcare system in 2015 in the West of England. Less than 20% of those scored in the community had a score high enough to refer to the ED (≥ 5). The authors suggest their findings are reassuring should reassure us that outpatients are not being overtriaged by NEWS. I'm looking forward to a follow-up study to see how emergency visits were affected.

Reader's Choice: are nights worth it?

In the USA, night working for consultants (also known as attendings) is a given. Not that any of us love it. At non-teaching hospitals, there is no one else, and in the academic setting, we are expected to safeguard the patients and provide teaching to the trainees, 24/7. In the UK, where emergency medicine consultants have only recently started working nights and, where senior registrars are likely as experienced as many US residency graduates, it is certainly worth asking whether consultant night working is beneficial. In this month's Reader's Choice, Penn *et al.* report on a time series analysis of waiting times and adverse events before and after introduction of a EM Consultant night working at a large university hospital. No significant differences were found. However, outcomes like patient satisfaction and trainee education were not studied, and one has to wonder if there is subtle difference in the shift with a consultant at the helm? Or maybe it's just our professional duty? You can discuss that on your next night shift (or just shut your eyes for a few minutes).

There's more in this issue, including whether and how we could use the Shock Index in a general population of ED patients, and a study on outcomes of non-invasive ventilation in older patients. We have other big news. *EMJ* is launching a new article type for Quality Improvement articles. See the editorial by Edward Carlton and Simon Smith for the what, why and the how to.