



Highlights from this issue

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Caroline Leech , Associate Editor**Frequent attenders: a time for reflection**

On a recent night shift, my Emergency Department (ED) nursing colleagues were discussing the patients we see regularly and know well. Within a few minutes, they had listed 25 names. Frequent attenders are a very heterogeneous population and include patients with long-term brittle health conditions with high rates of hospital admission; those with Medically Unexplained Symptoms or chronic pain; and patients with substance abuse or mental health problems. This month's article by Greenfield and colleagues used Hospital Episode Statistics for English Emergency departments in the financial year 2016–1017 to assess the rates of frequent use. Of note, they removed duplicate attendances on the same day. 1 in 10 patients attended the ED more than three times a year. However strikingly 1.2% of patients attended six times or more a year and these accounted for 7.6% of total attendances (over one million attendances to ED). It is probably this group where there might be an opportunity to reduce ED use with innovative patient-focused solutions. However, as Ellen eloquently describes in the month's Editorial, these patients 'should be seen as individuals with needs unmet by the general health-care system' and while identified in ED the difficulty is that their management requires a shared responsibility between primary care, community psychiatry, social work and hospital specialists.

The flow of emergency care use after suspected seizures

Most seizures are self-limiting and do not require emergency treatment. Despite this, an ambulance is often called by bystanders and the patient conveyed to hospital. The team at Sheffield aimed to assess where efforts might be best placed to reduce urgent and emergency care use for this presenting condition. They successfully linked data from Yorkshire Ambulance Service emergency calls with ED attendances and hospital admissions to track the flow of patients. Seizures made up 2.8% of all ambulance incidents and were generally categorised as the most urgent blue-light response. They found 72% of patients were conveyed to

hospital following a suspected seizure and 45% of patients were admitted (although I suspect a number of these were for short-term observation only). The challenge now is to identify potential interventions to improve performance.

Automated external defibrillators: some challenges

Two papers on AED's this month. The first, by Derkenne *et al*, assessed whether the event recording of heart rhythm and shock delivery from public accessed AED's in Paris could be effectively downloaded and interpreted. This isn't routinely done in the UK but could provide useful clinical diagnostic information as well as assess bystander actions for CPR research and education. The authors found that matching the recording to the name of the patient was inadequate, some recordings could not be retrieved, and the overall quality for interpretation was poor. It seems there is still some work to do by manufacturers to improve the technology and usability of this function. The second paper by Fortington and colleagues, reviewed 14 sports club facilities in Australia twelve months after they had obtained an onsite AED as part of a government programme. Some common difficulties emerged in implementation including concerns around security inhibiting accessibility; inadequate signage and AED maintenance; and inconsistent engagement with a club medical emergency plan. These findings would be relevant to small community AED's and schools, as well as local sports clubs.

How likely do ED attendees think resuscitation is to be successful?

We know that the majority of our patients and relatives are likely to be overly optimistic regarding the success of CPR. In this study, a group from California surveyed 500 adults in the ED waiting room to assess their source of information, their preferences for CPR, any confounding factors for their beliefs and their estimated success rates of CPR. The findings are unlikely to surprise you but remind us that most peoples lived experience of resuscitation is very different from ours and will influence their expectations accordingly.

COVID-19 clerking out of the danger zone

'Close Air Support' (CAS) traditionally refers to the use of military air assets to support ground forces who are in proximity to a hostile target. I'm



therefore not sure that this is the right terminology to describe junior surgical outpatient doctors clerking a suspected COVID-19 patient remotely via telemedicine before the ED physician goes in to physically assess them. However, the authors from Singapore do present a novel method of using relocated staff to support the ED workforce and shorten the patient journey, while maintaining reduced viral exposure to staff.

Are you using lung ultrasound for COVID-19 in the ED?

Lung ultrasound (LUS) has previously been described as the 'stethoscope of the new millennium' and this months practice review provides a comprehensive guide to ED ultrasound use for COVID-19 at a time when stethoscopes are not around our necks. During the disease process, changes in the lung parenchyma tend to begin in the distal regions of the lung so diagnosis of COVID-19 pneumonia is well suited to a surface imaging technique such as LUS. Chest x-ray has a low sensitivity (missing up to 40% of confirmed cases) and CT has issues with radiation exposure, transfers, decontamination, and as a limited resource. Lung ultrasound is already established in critical care pathways to monitor daily progression of COVID-19 pulmonary disease (in response to treatment such as recruitment, PEEP or proning) but I'm still not sure how it would change my management in the ED. The authors suggest it could have a role in identifying COVID-19 pneumonia in clinically well patients (but with risk factors for severe illness) who would then go home with pulse oximetry and follow-up monitoring.

Thinking of our colleagues in Beirut

On 4th August 2020, a catastrophic explosion of ammonium nitrate tore through the Lebanese capital killing and

Primary survey

injuring thousands, and destroying whole neighbourhoods. Some hospitals were severely damaged in the blast with structural instability and staff/patient victims, but were still inundated with severely

injured casualties. 'The view from here' provides a jarring insight into the initial hours after the tragedy from three medical students who returned to their university hospital to lend help. We send best wishes

to all our emergency colleagues in Beirut for recovery and restoration.

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