Highlights from this issue

doi:10.1136/emered-2019-209391

Ellen J Weber , *Editor in Chief*

The profile of major trauma is changing; the very young and the very old are now as likely to be victims of trauma as the middle-aged man in a road traffic injury or a youth victim of stabbing. This month's issue, with a strong focus on trauma, begins with a commentary (this month's Reader's Choice) about how this new face of trauma is often concealed – so-called “stealth trauma.” The child, often brought by car and not EMS, bypasses the usual trauma system entirely. The elderly patient who arrives by ambulance after a fall from standing to the kitchen floor, with no obvious bleeding, and less ability to notice or complain of pain, may not be triaged to a trauma centre, or even be assigned the highest acuity in the ED, yet could be suffering from multiple rib fractures, a hemothorax, pulmonary contusion, and a splenic hematoma. We are now challenged to figure out how a trauma system, set up to identify major trauma largely based on high energy mechanisms, can meet the challenge of this new demographic and epidemiology of injury.

Not by accident, “Blunt chest trauma in the elderly” is the subject of this month's Expert Practice review. Yes, while a 25 year who breaks a rib or two after a bicycle crash will likely have an uneventful course, the 68 year old taking anticoagulants for atrial fibrillation, with underlying COPD, and no help at home, will not have an easy, or assured, recovery from a similar injury. Assessment, imaging, pain control, and deciding where the patient should be admitted are all critical in these patients and are covered in the review. (As a side note- you may want to listen to our podcast on the HECTOR project, a multi-disciplinary team approach to elderly people with trauma which won the 2018 BMJ Award for Emergency Medicine. <https://soundcloud.com/bmjpodcasts/bmj-emergency-medicine-award-the-hector-project>).

Massive Transfusion Protocols specify a fixed ratio of red cells, FFP and platelets.

However, there remains uncertainty about the optimum ratios. A study from the Netherlands reviewed the massive transfusion protocols (MTP) from all 11 of its trauma centres, finding that ratios of red cells/plasma/ platelets varied considerably among hospitals. Hospital procedures for MTP often didn't follow either the Dutch Ministry of Defense guideline or the European or ATLS guidelines. This article provides an excellent summary of what current guidelines actually say, which you can use to see if your hospital is practicing accordingly.

A very informative and thought-provoking read in this month's issue is our Concepts paper. This article explores the experience of piloting a program for uncontrolled organ donation in the ED of Royal Edinburgh Hospital. Controlled organ donation involves the planned withdrawal of care in anticipation of circulatory arrest; uncontrolled donation occurs in a patient who has experienced unexpected and irrecoverable circulatory arrest. Uncontrolled donation has proven to be successful in increasing the number of available organs for transplant in Spain, Italy and France. The paper takes you through the many steps of conception, planning, and ethical approval, and the systems and personnel needed for such a program. For those of you not aware, the UK is set to commence its opt-out policy for organ donation April 2020; this article may therefore provide useful insights into how organ donation can be handled in an ED.

Editor's Choice: Pain is the most common reason that patients attend our emergency departments – and yet study after study tells us that our pain management is suboptimal. “Pain is the fifth vital sign,” we're told; posters in our EDs encourage patients to ask for pain medication. In the USA, triage nurses are required to ask about and chart both the quality and degree of pain; a pay-for-performance

measure rewards (or penalises) hospitals based on the time it takes for patients with long bone fractures to receive pain medication. Why aren't we better at this? Sampson *et al* performed hours of observation, interviews and analysis of documents at three EDs in the North of England to understand the problem. They found that pain management was not perceived to be a core organisational priority for which staff were held accountable, was not prioritised in training, and that the systems of care within the ED did not prioritise pain management. All of us should take another look at our systems and ask whether they are really designed to meet our patients' number one need.

A report published in 2016 suggested that “delayed transfers of care” (DTC) – those inpatients that no longer need an acute care bed but remain in the hospital – are responsible for boarding of admitted patients in England's EDs, resulting in failure to meet the 4 hour target. It would be easy to make that assumption given that over the years DTC's have risen at approximately the same rate as breaches of the 4 hour target. So, cause and effect? Not so fast say the authors of the paper “The impact of Delayed Transfers of Care on Emergency Departments common sense arguments evidence and confounding.” In this study, Keogh and Monks show how the analysis fails to account for the longitudinal nature of the data, and that in fact, there is only a very weak correlation between these two variables. Although the title may be a little daunting to non-statisticians, the paper is an easily digestible explanation of the principles involved, helping us all become just a bit more savvy (and sceptical) about interpreting observational data.

ORCID iD

Ellen J Weber <http://orcid.org/0000-0002-0094-1973>