



Highlights from this issue

Richard Body , Deputy Editor**Do drunk tanks work?**

Alcohol Intoxication Management Services (AIMS) have been deployed in the United Kingdom to unburden crowded EDs at times of high demand, by receiving and managing patients who are apparently intoxicated, reducing the need for transport to EDs. The Evaluating the Diversion of Alcohol Related Attendances (EDARA) study investigated the impact of those services. My own department in Manchester participated in this study so it is a pleasure to read the results. There were marginal gains for ambulance response times, but the evidence suggests that the services may not be cost-effective. Perhaps, therefore, the ED will still be the 'drunk tank' of choice.

Do we need a test for GHB?

Gamma-hydroxybutyrate (GHB) is a commonly used recreational drug that often causes patients to present to the ED with a decreased level of consciousness. Smits *et al* asked emergency physicians to record what they believed to be the causative agent when they were treating patients with apparent drug overdoses. They then used gas chromatography to screen urine samples for GHB. They found that emergency physicians had 93% sensitivity and 63% specificity for GHB overdose. The authors conclude that a bedside test for GHB may therefore be necessary. Do you agree? Would such a test change your management? Is there a clinical risk associated with false negative diagnoses? Read the full paper and make your judgement.

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Welcome to the July 2021 edition of the Emergency Medicine Journal. As we continue to emerge from an unforgiving first two waves of the COVID-19 pandemic here in the United Kingdom, there is unfortunately no respite for Emergency Departments. Attendance rates continue to increase and once again we are under pressure. This month, we have a special focus on trauma. Reflective of our evolving daily practice, however, we continue to keep our eye on COVID-19.

Major trauma: should 24 year-olds go to Children's Major Trauma Centres?

The United Kingdom's Trauma Audit and Research Network (TARN) is a jewel in the crown of its major trauma network. All major trauma centres (MTCs) and trauma units now feed data into TARN, which provides an outstanding opportunity for epidemiological analysis on a national scale. This month, Evans *et al* ask whether severely injured adolescents obtain better outcomes when treated at MTCs dedicated to the care of adults, children or both. Outcomes were better at children's MTCs. Interestingly, 'adolescents' were defined as those aged between 10 and 24.99 years. So should we be sending severely injured 24 year olds to children's MTCs? Read the full text and put your critical appraisal skills to the test!

Focus on chest injury

In this episode we publish three articles on blunt chest wall injury. Avery *et al* ran a survey of UK emergency physicians, asking how they would manage several cases of traumatic pneumothorax. Take a look and decide for yourself: would you insert a chest drain? It seems that emergency physicians often disagree on this! Perhaps this work will pave the way for further research in the area. Battle *et al* also pave the way for what may be exciting further research in this field, presenting the results of the ELECT trial. This was a feasibility study evaluating a physiotherapy intervention for patients with blunt chest wall injury. Finally, Daskal *et al* have examined the significance of flail chest. We routinely look for evidence of flail segments when we identify rib fractures, and emergency physicians are likely to be universally aware that their presence indicates a

significant injury. But what does the evidence tell us? How often is a flail segment associated with other significant intrathoracic injuries? Read the full paper to find out.

Should you dorsiflex the wrist for arterial cannulation?

When inserting an arterial cannula, I would always dorsiflex the wrist. I think this is generally an accepted practice. When cannulating the radial artery of a sedated and ventilated patient, I would routinely ensure that the wrist is firmly fixed in a dorsiflexed position prior to commencing the procedure. In this issue, Xiao *et al* present the results of a randomised controlled trial that may challenge that. They randomised patients to receive arterial cannulation with the wrist held in dorsiflexion or in the neutral position. Interestingly, there was no difference in the rate of first attempt success, the primary outcome. While there was a slightly greater success rate in the dorsiflexion group, it did not reach statistical significance. Time to successful cannulation (a secondary outcome) was, however, significantly shorter in the dorsiflexion group. The authors conclude that dorsiflexion may not be necessary. What would you do for your next patient based on these findings?

Ultrasound-Guided reduction of distal radial fractures

With the rise of the use of ultrasound in emergency medicine, an interesting use case is to guide the reduction of distal radial fractures. It seems appealing: a quick bedside ultrasound scan could verify successful reduction without transfer to the x-ray room, potentially avoiding the need for a repeat procedure. Malik *et al* present the findings of a systematic review that asks what the evidence is for this practice. Interestingly, while ten studies were identified, there are some important limitations to the available evidence. In the randomised controlled trials that have been conducted, results have been mixed, to say the least. Emergency physicians ought to be familiar with these findings, and use them to decide whether you're convinced that the time required to undertake a bedside ultrasound scan for these patients is justified, or whether the radiograph should remain the default investigation.

