



## Highlights from this issue

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Welcome back to the latest edition of the EMJ. It's high Summer here in the Northern Hemisphere and our hopes that COVID-19 would be a distant memory by now are sadly broken. We are in wave  $n+1$  at the moment (where  $n$  depends on where you are in the world), but there is hope in sight as vaccine roll outs continue around the world.

This month our Editor's choice is the PRIEST study. This huge observational trial of COVID-19 19 patients presenting to UK emergency departments gave us essential information on risk assessment in the COVID-19 pandemic. It's a fantastic example of how a trial can be rapidly delivered in a pandemic and a lesson in how we need to plan for the pandemic after COVID-19. The study is particularly useful in that it focuses on information available to the emergency clinician in the form of well-known scores such as NEWS2 as opposed to data that may be available much later (such as some laboratory testing). While therapeutic trials of repurposed drugs such as the RECOVERY and REMAP-CAP trials have received much of the publicity in the wake of COVID-19 we must remember that as emergency clinicians it is diagnosis, prognosis, risk assessment and disposition decisions that are at the core of our specialty. The PRIEST study is a great example of how this can be done in a pandemic.

Keeping with a COVID-19 theme Richards *et al* examined the evidence for prone positioning for non-intubated hypoxic COVID-19 patients. Despite the millions of cases worldwide and the enthusiasm for this technique the evidence base from 31 trials is actually very poor. There are theoretical physiological advantages of course, and anecdotally short-term improvement can be seen. However, it is still not clear whether this translates into important patient related outcomes. It's clear from this study that we need more data to support clinical practice and from well-designed clinical trials.

Leading a cardiac arrest is a complex task that even experienced clinicians can find cognitively overwhelming. There is the 'in the moment' task of sticking to an algorithm while at the same time trying to figure out a more strategic plan for the patient. Few individuals can do both

effectively which is why my colleagues have been teaching the concept of splitting roles to cognitively offload the strategic leader to strategically direct the arrest. I was therefore delighted to see this concept tested in the CANLEAD trial using a simulated model of cardiac arrest and nursing team leaders to run the ALS algorithm. In 20 simulations involving 120 participants they found improved overall team performance. Whether this would translate to better outcomes for patients in real world settings remains to be seen, but it has face validity and this study supports further work. It's also a welcome reminder that nurses are perfectly capable of running cardiac arrests, and some of the best resuscitators I know work with nurses in exactly this manner.

Cardiac arrest is a condition (among others) where debriefing is important and so it's good to see a study of the use of a structured debrief tool from Sugarman *et al* who report a quality improvement project looking at implementing the 'TAKE STOCK' tool, adapted from the Stop5 tool. QIP reports are relatively new to the journal, and we hope to highlight effective and interesting projects that can make a real difference to clinical care. The QIP shows a broad welcoming of a structured approach to debriefing from all staff members, and articulates a path for their introduction. If you are not already using a debriefing tool then this QIP may well help your department embed this important task.

As I write this there is a lot of media attention in the UK regarding the number of paediatric attendances to UK emergency departments with colleagues such as Damian Roland from Leicester working hard to educate the public on what fever really means in the paediatric population. While most fevers are benign we all know that it can also be a marker of infection and so we have two paediatric studies looking at this in August. Chong *et al* looked at children under 3 months which are a notoriously difficult group to differentiate serious from benign disease. In their cohort the incidence of severe disease was high (33%), but there are clues in the heart rate variability, temperature, and gender may help. In a less risky group Mallet *et al* have looked at the

prescription of antibiotics in paediatric sore throat finding a fair amount of variability between clinician choice and more formalised scoring mechanisms. It's a good story to remind us that research findings (in this case scoring systems) rarely perform or penetrate clinical practice in the way that we would hope or anticipate.



Sticking with paediatrics I was interested to read a paper that made me stop and think about my own practice for Toddler's fractures. My approach has been symptom led varying from the rare use of plaster of Paris through splints, and often very little indeed if the patient is not distressed or in pain. This month we have a randomised controlled trial from Australia comparing above knee POP to a controlled ankle motion boot. They found that a controlled motion boot is easier to live with and allows a faster return to activities of daily living and without any healing problems. However, I'm still left wondering if either of these levels of intervention are necessary for all patients.

There's lots more in this month's edition but I'll end with a reminder that our perceptions of emergency care may differ from those of our patients. Bull *et al.*'s systematic review of patient experience in the emergency department is enlightening with two major themes, one of the interactions between patients and staff and the other with the environment of the emergency department. There is much to reflect on here and perhaps time to look at our departments from the patient perspective.

