Highlights from this issue

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Welcome to the February 2022 issue of the Emergency Medicine Journal. COVID-19 continues to dominate headlines and remains important to our practice. In this issue, we have published four more articles relating to COVID-19. In addition, we have four valuable pieces relating to out of hospital cardiac arrest; three relating to patient experience and an interesting 'in perspective' piece on the use of apnoeic oxygenation.

COVID-19: focus on the critically ill patient

This month we have published the results of a multi-centre randomised controlled trial from Argentina, evaluating the safety and efficacy of hyperbaric oxygen therapy for severely hypoxia patients with COVID-19. The trial was relatively small (40 patients) but was terminated early due to overwhelming evidence of efficacy. Patients in the hyperbaric oxygen group recovered more quickly from hypoxia. Could this trial have identified an important new treatment for patients with COVID-19 and refractory hypoxia? You should also be sure to read the accompanying expert commentary by Dr Kirby, who helps us to interpret the significance of these intriguing findings.

Elsewhere in this issue, we focus on the allocation of critical care resources. By now, we are all too familiar with the potential for COVID-19 to saturate critical care beds during waves of infection. At some times of high demand, clinicians may be faced with important decisions about how to allocate scare critical care resources. Which patients should receive beds? Should they be given to the most critically ill patients, or should beds be reserved for patients with the best chance of recovery? Whittington *et al* present the findings of an intriguing discrete choice experiment with the United States public, exploring their attitudes and preferences about how such scarce resources should be allocated. The findings are a must-read for emergency physicians who are faced with such decisions on a regular basis.

Out of hospital cardiac arrest

Out of hospital cardiac arrest (OHCA) caused by hanging is thankfully a relatively rare presentation in the Emergency Department. Given its relatively rarity, the publication of a retrospective cohort study by Turner *et al* reporting the epidemiology and survival rates at a UK ambulance service over 5 years is very informative. Survival rates were unfortunately very low.

Similarly, Doan *et al* have reported on the epidemiology and survival rates following traumatic cardiac arrest in Queensland. The authors also explored factors associated with survival. Interestingly, given the relatively recent publication of landmark trials such as AIRWAYS-2 (which identified no benefit with advanced airway management in out of hospital cardiac arrest), Doan *et al* found that advanced airway management was associated with improved odds of survival to hospital handover.

Elsewhere, Shibahashi *et al* have validated two prognostic scores for patients with OHCA. The scores incorporate some variables that are only available after some in-hospital investigation (eg, creatinine and lactate concentrations) but the authors propose that they could be used to identify patients for whom further interventions may be futile with high accuracy. Read the full paper and decide for yourself whether you think these scores could be used to guide clinical decisions in your practice.

Finally, we know that the 'awareness time interval' (the time from witnessing cardiac arrest to activating emergency services) is an important prognostic factor for patients with OHCA. Lee *et al* have explored the association between location of cardiac arrest and the awareness time interval. Interestingly, patients who sustained OHCA in private residences and nursing facilities had longer awareness time intervals than patients who sustained OHCA in public places, suggesting that there may be a need for better education to improve the speed of response in those environments.

Focusing on patient experience

In this issue, we are also privileged to publish three pieces evaluating patient experience in the Emergency Department. First, Yan *et al* reported a qualitative evaluation of the experience of diabetic patients who had presented to the Emergency Department with hyperglycaemia. The themes identified are relevant to all practising emergency physicians. How effectively do we communicate discharge instructions to our patients? What do patient experiences tell us about how we might improve the care that we provide?

Speaking of discharge instructions, Hesselink *et al* report on a before and after pilot study evaluating the use of a simple 'teach-back' method for discharge instructions in the Emergency Department. They report that patients who received discharge instructions using the 'teach-back' method were less likely to re-attend the Emergency Department and showed greater retention of information relating to their treatment and diagnosis. Could this simple method be used to good effect in your Emergency Department?

Finally, and linking with the discrete choice experiment asking 'who should get the scarce intensive care unit bed?' mentioned above, Walzi *et al* present the findings of a systematic review of factors influencing decisions to limit treatment in the Emergency Department. Whittington *et al* reported the perspective of the public about how critical care resources should be allocated; wheras Walzi *et al* have synthesised the available evidence for the factors that guide clinicians in making decisions about ceilings of care.

Apnoeic oxygenation

Finally, the concept of apnoeic oxygenation for patients undergoing rapid sequence intubation (RSI) in the Emergency Department has gained popularity in recent years. In this issue, Dr Caputo presents an informed critique of the evidence for the use of apnoeic oxygenation, which is more than enough to make us stop and question its value in our practice.

As always, I hope you will enjoy reading this issue of the journal as much as I have.

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