



# Primary survey: Highlights from this issue

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Welcome to the September 2023 issue of the Emergency Medicine Journal. This month we have a trio of papers on health services: a qualitative study exploring views of NHS 111 from the perspective of the Emergency Department (ED); a retrospective study looking at the impact scrapping the UK 4 hour process target; and an evaluation of an innovative service to try and avoid ED attendances for older adults. We also cover a range of topics from the experience of feeling uncertain as a consultant to fluid biomarkers of traumatic brain injury, a look at the use of isopropyl alcohol as an anti-emetic and a survey of current practice with regard to the size of chest drains used for patients with traumatic pneumothorax. I'll take you through some of the highlights.

## The only thing I know is that I know nothing: the lived experience of new ED consultants

I can vividly remember my first months as an ED consultant, though it was some time ago now. It felt lonely to be the consultant on-call, responsible for making decisions that could have such important consequences for patients but suddenly having nobody more senior to defer to when needed. This month, we publish a paper reporting on the experiences of uncertainty felt by five new Emergency Medicine consultants (attendings). The themes identified are intriguing: from sentiments touching on imposter syndrome and feelings of inadequacy to the positive impact

of having senior role models who are able to openly acknowledge their persistent uncertainty.

## Does sniffing the alcohol wipes reduce sickness?

You may have seen some of the published evidence looking at whether inhaled isopropyl alcohol (which is commonly contained in the wipes used to prepare the skin prior to intravenous cannulation) can reduce nausea and vomiting among patients attending the ED. In this issue, we publish a systematic review and meta-analysis of this simple, non-invasive treatment. The meta-analysis confirms what you may have read: that isopropyl alcohol does appear to have a beneficial effect in this context. So, next time you treat a nauseous patient in the ED, will you use the isopropyl alcohol to set the patient on a path to receiving an intravenous anti-emetic or will you ask the patient to try sniffing it first?

## Is it time to unleash the 'troponin of the brain' in head injury?

When we treat patients with head injury in the ED, there's really only one investigation that we ever look to use: a cranial CT scan. But does everyone need a CT scan, or could some scans be avoided by testing for biomarker levels? And what if the CT scan is normal? Does it always mean that the patient has an excellent prognosis? In fact, we know that some patients will still go on to experience very problematic post-concussion syndrome. If we could recognise that early using biomarkers, perhaps we could develop interventions that will help to reduce the symptoms and accelerate recovery. Newcombe *et al* report an outstanding narrative review of this topic, telling you all you need to know about the biomarkers of interest, how they work, and whether the current evidence justifies their clinical use at this moment.

## Was the 4-hour target a help or hindrance?

For many years, the UK had a 4 hour ED target meaning that patients ought to stay in the ED for no longer than 4 hours from the time of arrival to discharge, admission or transfer. While many people looked on

this favourably for the impetus it gave to reducing exit block, others criticised some of the behaviours it encouraged. The study reported by Momesso *et al* describes the impact of removing the 4 hour target at one English ED, and gives some excellent insights into this issue. While the number of short-stay admissions fell with removal of the target, overall length of stay in the ED increased. Given what we know about the impact of ED crowding and length of stay on patient-related outcomes including mortality, is this a fair trade-off?

## What do ED clinicians think of NHS 111?

In the UK, patients can call 111 for non-emergency health issues and receive advice on the most appropriate way to access the required healthcare. NHS 111 is staffed by call handlers who refer to a series of pre-populated decision trees. After the onset of the COVID-19 pandemic, the NHS 111 First initiative was set up to allow some patients to receive a pre-booked appointment at the ED, theoretically cutting out the waiting time. MacLellan *et al* report a qualitative study to evaluate ED clinicians' opinions of the current NHS 111 service. The findings revealed some frustration about unnecessary referrals to the ED and the ineffectiveness of the pre-booked appointment system. They provide very valuable insights into the organisation of telephone triage services. The big question now is: if the current system isn't right, what does an excellent system look like?

As well as these gems, there's so much more in this issue. You can read a survey of emergency physicians that highlights significant variation in practice when inserting chest drains for patients with traumatic pneumothorax, about the accuracy of a novel device for measuring transcutaneous carbon dioxide levels and about an innovative initiative to reduce ED attendances for older adults. Finally, you can read the report of the UK's most recent James Lind Alliance Priority Setting Partnership for Emergency Medicine, which identifies the current top ten priorities for research in the specialty.

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