




# Primary survey: highlights from this issue

doi:10.1136/emered-2024-214142

Ellen J Weber , Editor

*'Free vapes given to smokers at hospitals could help thousands quit, study suggests.'* And *'Calls for free vapes to be handed out in emergency departments.'*

These were the headlines describing this month's Editor's Choice, the Cessation of Smoking Trial in the Emergency Department (COSTED), when it was published on-line in March. Of course COSTED wasn't *just* about vapes. This randomised, controlled study conducted by Pope and colleagues at 6 UK emergency departments (ED) recruited patients attending for any reason who smoked daily. Intervention patients received 15 min of face-to-face smoking cessation counselling in the ED, an e-cigarette starter kit and instructions, and referral to a local NHS smoking cessation service. Controls received written information about a local NHS stop smoking service but were not directly referred. The headlines tell the tale (more abstinence in the intervention group), but the study sparked some other questions for us. Is it a good idea to use e-cigarettes in a smoking cessation programme? Isn't that just substituting one addiction for another? We invited experts in tobacco control to enlighten us on this question. Also, given how busy we already are, is this something our EDs should be doing? We asked the chairman of the RCEM Quality Committee to clear the smoke on that issue.

Co-located GP services are expected to help improve access and decrease ED crowding by caring for less critical cases. In the UK, Dr Alison Cooper and her team have been studying co-located GP services for some time, and, in this issue they summarise their findings in terms of 'programme theories', describing how the different models of GP co-location effect the roles of ED staff, GPs, and the patient journey. They report that their quantitative analysis showed no one model is superior, nor have any of the models improved ED crowding and flow. In his accompanying "In Perspective" article, Australian emergency physician (EP) Dr. Gerard Fitzgerald explains why GP co-location, and other potential solutions to crowding, have failed to live up to expectations. The growth in emergency care, he writes, is

a 'genuine expression of the community's healthcare need and not the result of anyone's failures'.

Though still in its infancy, artificial intelligence (AI) shows some promising applications for improving care and flow in emergency departments. In prior studies, AI improves the accuracy and speed with which radiologists read images. That might help us a bit by getting reports faster but... what if AI could improve *our* accuracy, perhaps allowing us to make discharge decisions without waiting for that 'formal report'. Warman *et al* asked five experienced EPs in the US to read a series of head CT's, some with intracranial haemorrhages (ICH), others normal. When they re-read the films (differently ordered) with the aid of commercial AI software, accuracy for detecting intracranial haemorrhage increased and was actually better than the mean accuracy of 3 general radiologists reading the same films individually without the software. The EPs also were better able to identify the type of ICH using the software. This is what is called a 'reader study' so we would definitely want to see how the software performs in the ED with real patients.

How do you manage a patient with AKI? Fluid, diuresis, vasopressors? It depends. Knowing the subtype of AKI is critical to selecting the appropriate therapy, and it would seem that ultrasound would be the ideal modality to distinguish the cause. However, as reported in this month's Reader's Choice, Aslaner *et al* from Turkey applied the Venous excess ultrasound (VEXUS) protocol to 262 patients with AKI and found that while the test characteristics were good for cardio-renal AKI, and fair for hypovolemic AKI, VEXUS was not useful for diagnosing AKI due to systemic vasodilation or renal causes. In short, VEXUS should not be used in isolation to try to make a diagnosis of type of AKI.

Our Letters (sometimes known as Research Letters) are an important citable format that succinctly summarise important findings for our readers. We have a number in this issue that we think you'll find important reading. Liu and



colleagues performed an analysis of the National Vital Statistics System in the US and found an 'alarming' increase over the past two decades in mortality from intra-abdominal infections in young people (25-65), even while mortality rates in those over 65 have declined over the past decade. Clearly more research in this area is needed but, in the meantime, we may need to increase our vigilance in caring for these younger patients. Another Letter concerns the dilemma of what to do when a final reading from radiology recommends a repeat chest x-ray for follow-up. Call the patient? The GP? Headon *et al* describe what happened in their ED in Ireland when their ED took on the task of ordering these films, rather than referring to the GP. A good lesson on why routine ordering is probably not the best approach.

Finally, I call your attention to two new additions to the EMJ this month. We begin publishing selected Best Practice RCEM guidelines, making them available to readers beyond the UK. A commentary explains how these guidelines are created. This issue includes a very useful guideline on the perplexing problem of Cannabis Hyperemesis Syndrome.

You may have already noticed the other addition: the podcast logo at the top of this page. That's a direct link to our monthly Primary Survey podcast where editors Rick Body and Sarah Edwards discuss these and other papers in this issue, and of course, every issue. I'm sure you'll enjoy it!

**ORCID iD**

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

