

Highlights from this issue

doi:10.1136/emmermed-2011-201078

Darren Walter, Deputy Editor

This month we range from Politics to philosophy, from basic science to standards of care. There is a spread of material on the resuscitation of cardiac arrest and lots of pre-hospital care; triage at 'front' and 'rear', trauma transfer times, airway care in the field and even how to improve ambulance safety.

The meaning of words

In this month's editorial, Hughes (*see page 90*) shows how easy it is to become confused with the political language of the performance culture in UK Emergency Medicine and translates some into simple terms that can be understood! On a much simpler and certainly more fundamental level, Body and Foex (*see page 91*) consider the philosophical difference between pain and suffering. Do we see and try to manage the disease/injury or care for the patient? Try their thought experiments to find out.

Real science

Tura *et al* (*see page 108*) report a double-blind RCT involving the administration of metoclopramide. This is short, to the point and provides a clear answer. Alongside it, a paper from Tong *et al* (*see page 113*) is a more complex analysis of the potential value of procalcitonin as an acute phase marker in exercise related hyperthermia. No test is perfect, but does it have a role in predicting outcome in this group of patients? As extreme sporting events are increasingly popular, these cases will follow.

Standards of care

Holla describes a small study that makes a challenge to the dogma around cervical spine immobilisation. Is a cervical collar necessary with blocks and tape? It has its place, but is it as critical as we have come to believe (*see page 104*)?

Fuller *et al* use the TARN data registry to report on the current state of massive blood transfusion in UK trauma care. With the knowledge 'bleeding in' [*sic*] from the military experience around resuscitation using the 1:1:1 red cells,

plasma and platelets ratio, there feels to be a therapeutic revolution about to take place. This analysis outlines the current state of UK practice (*see page 118*).

Cardiac arrest

The best resuscitation science seems to involve extensive collaboration and it is evolving at a phenomenal rate. Chestnut *et al* report from the Resuscitation Outcomes Consortium on the incidence of recurrent cardiac arrest after ROSC in the out-of-hospital environment. In their study group, the rate of deterioration was reassuringly less than you might imagine (*see page 129*).

Ilper *et al* (*see page 95*) illustrate how significantly the changed resuscitation guidelines from 2000 to 2005 reduced the 'Hands Off Intervals' for basic life support. With the 2010 guidelines now in use, it might seem a little dated, but the message is very clear. In a third paper on resuscitation, Storm *et al* (*see page 100*) point out that while post-arrest hypothermia is an increasingly accepted standard of care, the evidence is for those post-VF arrest. They report on a heterogeneous group of patients resuscitated from non-shockable rhythms and managed with hypothermia. Illustrating lots of the issues rather than and with longitudinal single-centre studies and they failed to show a significantly better outcome. The case for therapeutic hypothermia in all resuscitated cardiac arrests is still not made.

Trauma systems

Hsiao *et al* from Taiwan show that the introduction of a trauma bypass system in a rural area, taking significant isolated head injuries to a dedicated centre, did not affect patient outcome, but then neither did definitive airway management or long times to treatment. They discuss the conflicting messages that are coming out of their trauma system analysis (*see page 156*).

In a more evolved ambulance system, Cowan *et al* have surveyed the current state of pre-hospital anaesthesia in the UK and map this to the AAGBI guideline.

They reveal that there is a significant provision in the field and that it is entirely doctor-based. Data is being gathered but it is not using a common lexicon to allow for analysis. More worryingly, many practitioners perform very few procedures and 20% of systems do not have a formal 'difficult airway' plan (*see page 136*).

Triage: front and rear

Godet-Mardirossian *et al* (*see page 147*) and Meer *et al* (*see page 124*) give perspectives on the use of clinicians and computerised triage systems to aid dispatch and consideration of alternatives to an ambulance response and transport. They show that current systems are not reliable diagnostic tools but there has been some robust safety analysis and that, despite their limitations, they appear to be safe. With the 111 urgent care advice system about to be rolled out across the UK, this is timely.

Kirkby and Roberts (*see page 141*) reports a small study that looked at the awareness of a cohort of the British public about when to call for an ambulance and when an alternate action might be more appropriate. It seems that, with the exception of cases of stroke, people seem to know when to call. However it seems there is a long way to go in terms of knowing when not to call!

At the other end of the patient journey, Satterthwaite and Atkinson (*see page 160*) describe their experience of what they term 'reverse triage'; creating hospital capacity to deal with a patient surge by discharging from hospital, while responding to a maritime explosion. The process and timelines involved are worth considering for your own facility.

Ambulances are dangerous

Per mile of road travelled, an ambulance is the most dangerous vehicle on the road. Myers *et al* (*see page 133*) describe new technology, a 'toy', that seems to improve safety: driver feedback improves performance. Coming to an ambulance near you soon? Big Brother is watching you!

Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.

Emerg Med J: first published as 10.1136/emmermed-2011-201078 on 11 January 2012. Downloaded from <http://emj.bmj.com/> on June 5, 2025 at Department GEZ-LTA Erasmusnageschool.