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Keeping the customer satisfied

The main, and slightly uncomfortable, conclusion from the study of patient satisfaction undertaken by Walsh and Knott seems to be that the longer patients are in our emergency department the less satisfied they are. Perhaps that is inevitable. Suffering a medical emergency is no sensible person's idea of a good time, so our role is to ensure that it is as quick and painless as possible. In this respect the study offers some helpful pointers. Noise levels, trolley comfort and food quality were rated as being important by patients but associated with lower levels of satisfaction. Maybe it's a sign of age (or a cheap stethoscope) that I feel very sympathetic about the noise issue (*see page 821*).

Are emergency nurse practitioners quicker than doctors?

If shorter length of stay improves satisfaction then the study by Considine, Kropman and Stergiou suggests that patients managed by emergency nurse practitioners are likely to be more satisfied than those managed by doctors. Median emergency department length of stay for non-admitted patients was 1.7 h for those seen by emergency nurse practitioners, compared to medians ranging from 2.1 to 2.7 for various grade of doctor. Is this evidence that experienced nursing staff are more efficient than their medical colleagues, or is there a confounding factor? There seem to be some strong opinions about this on the medical internet discussions. Thoughtful comments are welcome though the EMJ rapid responses (*see page 838*).

Intensive care for asthma

Endotracheal intubation for children with severe asthma must be one of the most nerve-wracking procedures anyone can perform. Recognition of failing medical treatment and willingness to intubate can be life-saving, but the procedure itself is high-risk and challenging. This is shown in the data presented by Deho and colleagues who report that 36 out of 51 children intubated for acute asthma

experienced one or more complication during intubation or the early phase of mechanical ventilation. These included 27 cases of hypotension and 20 cases of severe bronchospasm (*see page 834*).

Diagnosis and management of syncope

Syncope is a common presentation to the emergency department with a variety of causes relevant to different specialities. Tattersall and Reed studied 540 patients admitted to hospital after an episode of syncope and found that a diagnosis was made in 33 (85%) of the 39 patients admitted to cardiology compared to 239 (61%) of the 392 patients admitted to general or acute medicine. There was also greater use diagnostic testing for those admitted under cardiology. This could suggest that the emergency department was doing its job properly in getting the right patients to the right speciality. Cardiac causes of syncope, such as arrhythmia and severe aortic stenosis, are more likely to benefit from treatment and thus require more detailed investigation and definite diagnosis (*see page 870*).

Do patients know how much paracetamol they can take?

Wood and colleagues undertook a survey of 910 emergency department patients to test their knowledge of whether various over-the-counter medications included paracetamol and what the maximum daily dose of paracetamol was. Rather worryingly, only 54% of the 853 respondents knew the correct maximum daily dose, although more reassuringly most of the wrong answers were lower than the maximum. Nevertheless, 5% of respondents stated doses higher than the maximum recommended. This is worth bearing in mind whenever we recommend paracetamol (*see page 829*).

Who are the repeat attenders?

A study from Singapore by Paul and colleagues examined the characteristics associated with patients who made five or more attendances at the emergency

department over the course of a year. The characteristics that independently predicted repeat attendance suggest that, in Singapore at least, repeat attendance is a problem for the elderly population. It would be interesting to know if these findings were reproduced in other countries (*see page 843*).

Ottawa knee rules in Iran

Ottawa rules have been developed for several complaints and tested in many settings. Jalili and Gharebaghi tested the Ottawa knee rule in Iran and reported sensitivity of 95% and specificity of 44% for fracture. The one missed injury was a tibial plateau fracture that was treated conservatively (*see page 849*).

Which supraglottic airway device is quickest to insert

Seconds count in prehospital airway management, so the time differences reported by Castle and colleagues are not trivial. They compared the time taken by 36 paramedic students to place an Igel, a laryngeal mask airway and a laryngeal tube airway in a manikin. The Igel came in fastest with a mean time of 12 s, with the laryngeal tube airway coming in at 22 s and the laryngeal mask airway at 34 s. The students obviously preferred speed with 63% backing the Igel and stating ease of use and speed of insertion as the primary reasons. The next step will be to move evaluation from manikins to humans (*see page 860*).

Return of the giant hogweed

Some people (or perhaps just me) will not be able to read the words 'giant hogweed' without thinking of a song by Genesis (Peter Gabriel era). Two 11-year olds from Manchester will have equally painful associations after developing photodermatitis from contact with giant hogweed on the banks of a local river. Fortunately their lesions healed with appropriate treatment, although we are warned that photosensitivity may last for months. The scars from exposure to progressive rock last much longer (*see page 883*).