

Writing a piece to tickle the interest of the reader in this month's selection, I found myself looking for patterns or themes. As usually happens, there is something for most tastes but August seems to have a strong paediatric thread, some toxicology and a little 'tip' for a tricky intervention.

## Children staying still

Paediatric trauma training talks about the anatomical differences in children and the problems it can cause. Pandie *et al* (*see page 573*) ask whether flat surface cervical spine alignment causes more problems than it solves. Cooperation can be poor, radiology difficult and a 'thoracic elevation device' might just be the ticket.

In terms of keeping our younger patients still, in two papers Babl and colleagues (*see page 577* and *see page 607*) show how sedation is achieved in a Melbourne children's hospital and how such changes can be introduced, but caution against developing complacency. Complications are unusual and compliance with safety procedures and documentation can slip as staff become increasingly familiar with the process.

One of the commoner reasons for sedating children is to facilitate the closure of facial wounds and Kidd *et al* (*see page 603*) describe the demographic profile of experience of this in a Scottish emergency department. I found the small number of cases requiring suturing a bit of a surprise, but the need for an understanding of the care of paediatric dental trauma is evident!

We all know that children are not small adults. The prehospital preparation for managing children is found wanting in a UK national survey by Houston and Pearson (*see page 631*); poor equipment provision, lack of specific paediatric training and limitations in on-line medical support. Things are moving in the right direction and reassuringly child protection seems to be well covered. A school report might read 'improving but could do better'.

## Toxic knowledge

With the rapid changeover of junior staff and them needing such a large amount of 'essential' knowledge to function, Cooper *et al* (*see page 599*) provide a salutary lesson about the use of local anaesthetics, even the most ubiquitous one. Do we really know so little and are we so poorly prepared to deal with the consequences?

Hamann *et al* (*see page 590*) support this, showing how the AAGBI guidelines on the use of Intralipid in the management of local anaesthetic toxicity have penetrated the system but that there is limited standardisation and it is often not found in the risk locations, emergency departments included.

Just because it is rare, does not mean we should not know how to approach it. Eskandarlou (*see page 616*) describes a bizarre case of self-harm from Iran. Attempted intracardiac injection of petrol is not an every day presentation!

## Bending the tip

How often have you struggled placing a gastric tube in a patient? Harvey and Cave (*see page 613*) show how innovative emergency physicians can be and suggest a simple trick to improve the success rate in a ventilated patient. Alongside this, Nejati *et al* (*see page 582*) share the outcome of a double-blind randomised trial into the use of ketamine to assist the placement of a nasogastric tube.

## Performance and quality

Wong *et al* (*see page 593*) from Canada describe a computer simulation model that puts numbers and graphs to the ongoing challenge of managing an urgent care service. Emergency departments are 24-hour, 7-day a week admitting facilities but hospitals only seem to discharge Monday to Friday 09:00 to 17:00 hours. It does not take a genius to see the potential development of a problem, but this system

status mapping seems to show not only an improvement in patient care at the front end, but shortened length of hospital stay and a reduction in the number of failed discharges.

Quality of care is not just about time. Andreu-Ballester *et al* (*see page 619*) show that the introduction of non-invasive ventilation in Spain has been patchy and is inconsistent. There is a wide variation in use between the public and private hospitals and, in those places that do use it, there seems to be little in the way of standardised delivery. Only 35% of hospitals actually have a protocol for use of this critical care intervention. Hmmmm...

## Prehospital and disaster medicine research

There is a dearth of good research in prehospital medicine. Lyon *et al* (*see page 637*) discuss their solutions to some of the practical difficulties encountered in the TOPCAT out-of-hospital cardiac arrest study. On a completely different scale, Chunguang *et al* (*see page 627*) report their observation of a cohort of crush injury patients from the Sichuan earthquake. The extrication of people who have been crushed for more than 24 h leads to amputation, multi-organ failure and death. In a disaster zone, this small group of patients demand a very high level of critical care support in a health system that is often overwhelmed and unlikely to be functioning optimally.

## Plants can bite twice

We have all seen people with corneal abrasions sustained from assaults by plants during that dangerous hobby, gardening. Sometimes there can be even more that meets the eye! Amisshah-Arthur and Gappe (*see page 647*) describe a particularly vicious combatant that comes back for a second bite; a case report with a message.