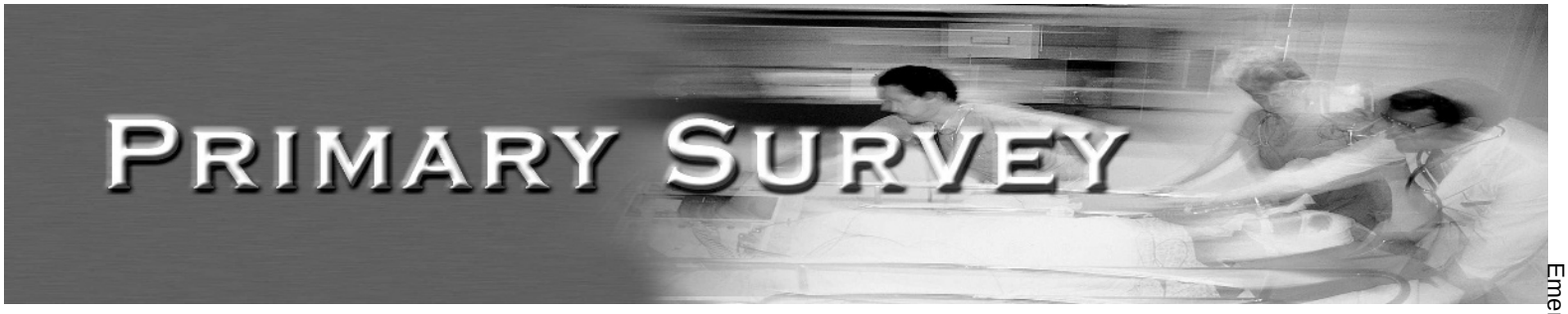

Kenn Mackway-Jones, *Editor*

CASE REPORTS

The new format of Emergency Casebook took effect at the beginning of the year; we hope you find this changed section useful and that the wider scope of cases in each issue keeps you both interested and informed. We know that you will have to get on to the internet to take full advantage of the electronic long, paper short (ELPS) cases—but we believe that this gentle nudge of case report readers towards the technologies of the twenty-first century is worthwhile.

As part of the ongoing review of the journal's processes the editorial team have decided to streamline the review system for case reports. Currently each report is sent out to two reviewers and proceeds through the editorial process in the same way as original research and reviews. The sheer number of reports we receive means that this approach puts considerable strain on the system—in particular decisions are often delayed for months and reviewers receive large numbers of assignments. In future the vast majority of case reports will be dealt with by the expanded editorial team. This will considerably speed up the process for authors and will also allow us to ensure that we use the time and considerable talents of our reviewers in a more focused way. Everyone should start to see the benefits over the coming months.

SELF-HARM, OVERDOSES AND POISONING

Our review section this month contains two substantial pieces of work that address self-harm, overdoses and poisoning. Alex Mitchell and Mick Dennis (***see p 251***) from Leicester use a FAQ format to ask 10 questions about attempted suicide and self-harm. Their answers are directed towards Emergency Department staff and are well worth a read. On ***page 246*** Sanjay Purkayastha and Colleagues from St Mary's, Paddington systematically review the much more specific topic of the use of cardiopulmonary bypass. While they found no high grade evidence they feel able to conclude that bypass is indicated in cardiotoxicity before severe hypotension causes hypoxic cerebral damage.

CHEST PAIN AGAIN

Paul Collinson and colleagues report the results of a substantial study into the utility of the troponins and ischaemia modified albumin in the rapid rule out of acute myocardial infarction in the Emergency Department. This is a well conducted study and deserves a careful read. In particular it is worth considering what reduction in specificity we are willing to accept in order to gain 100% sensitivity. Should a protocol that has no false negatives but a very high false positive rate be adopted immediately or is there room for debate? If you want to join the debate then send a rapid response.

PROCESS MATTERS

It's interesting for British Emergency Physicians, fresh from the battles of the four hour target, to hear about the ''process struggles'' of Emergency Departments around the world. In this issue we have a paper from the Pamela Youde Nethersole Eastern Hospital in Hong Kong that looks at the role of TRIAD. This is not about strong arm tactics – but about the use of doctors in triage (see and treat by another name). In another article, this time from the Queen Elizabeth Hospital in Bridgetown, Barbados, the process of care of patients is meticulously dissected.

TRIAGE

As anyone who has struggled to catch the slippery eel that is triage will know, the lack of a verifiable gold standard is a major impediment to good research. Lee Wallis and colleagues (***see p 291***) have attacked this problem head on, and report the outcome of their Delphi study that was designed to develop a set of criteria against which major incident triage systems can be measured. It's not a blood test or an x-ray, but it is progress. Hopefully the results of this process will allow better comparisons to be made in the future.

BLISTER AGENT

On ***page 296*** Le and Knudsen report practical experience of the effects of blister agent on exposed skin. It is interesting to note that there is a real risk of encountering these agents without the help of terrorists, and a reminder of what we might see if the mustards were deployed.

WORKING HOURS AND MAJOR TRAUMA

In an analysis from the UK TARN database Guly *et al* report on the effect of that time of presentation (in or out of hours) has on mortality from major trauma. If, like me, you think you know the answer to this question (doesn't everyone – it must be just the same as every other emergency) you should go immediately to ***page 276*** and see if you are right. I bet you get a surprise.