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Emergency Medicine & Trauma

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Providing seamless emergency care is the ideal for those of us who work in emergency medicine and intensive care. In the past, intensive care units were a closed part of the hospital, and admission was strictly controlled. This idea is obsolete now. It is heartening that we are providing more integrated care between emergency and intensive care. Intensivists need to go out of the ICU and take action earlier to stabilise and admit patients — before they are severely affected. We do this for trauma, and we are doing this for sepsis. We talk about the “golden hour”, but of course every minute counts. Can we take action even earlier for more conditions?

Our Cover Story addresses some of these issues. Starting with acute ischaemic stroke, Jason Van Schoor, Vivian Sathianathan and David Brealey argue that, when compared with other serious ICU diagnoses such as severe sepsis and long term ventilation, the outcome of AIS patients on ICU compares well. They suggest that this comparison should shake the historical reluctance that surrounds admission of stroke patients to ICU. When treating patients in cardiac arrest, targeted temperature management is the key intervention for improving neurological outcomes after cardiac arrest. Jean Baptiste Lascarrou and Jean Reignier discuss new data on the optimal timing and modalities of targeted temperature management. For burns management, regionalisation of centres has led to improved outcomes, argue Sam Miotke, William Mohr and Frederik Endor. They contend that the complexity of patient care, both in the short- and long-term, requires a well-prepared interdisciplinary team. Such implementation has been made possible by centre regionalisation, which consolidates expert wound care and critical care management, with benefits for patient outcomes. Next, Aristomenis Exadaktylos and Wolf Hautz provide a snapshot of the pre-hospital emergency system, focusing on Berne. Michael Reade provides a review of blast injury, outlining what to expect in civilian versus military injuries. He observes that mistaken preconceptions of the medical consequences of blast can lead planners and managers to allocate resources incorrectly. Civilian blast injuries are not rare, but most are not due to military explosives, meaning extrapolation from military texts is often inappropriate. Last, Anatole Harrois and Jacques Duranteau focus on the types of fluid available and their respective indications in the course of trauma resuscitation.

Our series on Infections concludes with an article on the ICU response to the Middle East Respiratory

Syndrome (MERS) Coronavirus by Hasan Al-Dorzi, Hanan Balkhy and Yaseen Arabi. They emphasise that prevention of healthcare-associated transmission should be the main focus of ICU preparedness.

In the Matrix section, Stuart McGrane, Heidi Smith and Pratik Pandharipande discuss acute brain dysfunction during critical illness. They outline risk factors, prevention and treatment, and reason that delirium monitoring and management may help decrease development and duration of delirium in adults and children. Next, Matthew Kirschen and Peter Le Roux focus on the current experience with clinically available neuromonitoring techniques in critically ill patients at risk for neurological compromise, but without overt acute brain injury.

Although finding evidence has got easier with electronic databases and the Internet, translating knowledge into practice can still take time before it has a discernible effect. aC3KTion Net in Canada is a knowledge translation network, and Nicole O'Callaghan and John Muscedere outline its work in quality improvement in our Management section. Next, we feature an interview with Daren Heyland, who directs the Canadian Researchers at theEnd of Life Network (CARENET), about the network's activities, which includes the development of innovative resources to prompt discussions about end-of-life care, both for patients and for health professionals.

It is fair to describe Michael Pinsky as a true leader of critical care. He is interviewed in this issue about some of the fundamentals of critical care he has been involved in over the years as a researcher, practitioner and leader.

New Year, New Name

In 2016 *ICU Management* changes its title. Since we began publication in 2000, we have always been the Official Management and Practice journal of the International Symposium on Intensive Care and Emergency Medicine (ISICEM). To better reflect the contents of the journal, we will bring practice alongside management to become *ICU Management & Practice*. Not only are we changing title, but the journal will be even bigger. I thank the Editorial Board for their continuing support, the many authors from around the world who write for the journal, and you, the readers. As always, if you would like to get in touch, please email editorial@icu-management.org

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