In this issue 16 APRIL

AUSTRALIAN HOSPITALS ILL-PREPARED FOR MASS EMERGENCIES

Australian hospitals are not prepared for a sudden influx of patients, as would occur with a mass casualty incident or an outbreak of disease, say Traub et al (*page 394*). Using United States benchmarks for surge capacity (the ability to provide acute care to both critical and non-critical mass casualties simultaneously), Traub and colleagues' national survey of emergency department directors reveals that, if a major incident affected 500 per million population (eg, about 1900 people in Sydney), our capacity to manage the crisis would vary markedly depending on where it occurred. Based on their audit of operating theatres, intensive care beds and x-ray facilities, most critically injured patients would face delays to operation and many would not receive timely access to intensive care. The less critically injured could face delays in access to radiological investigations. But measuring infrastructure, counter Robertson and Cooper on *page 388*, is just one approach to evaluating our preparedness for unpredictable events.

COPD ON THE RISE IN WOMEN

Asthma morbidity and mortality have fallen over the past decade, but chronic obstructive pulmonary disease (COPD) has not abated, and is on the increase in women. These were the findings of Wilson et al's analysis of several South Australian and national datasets (*page 408*). Between 1993 and 2003, hospital separations for, and deaths from, asthma steadily declined. Hospitalisation for COPD, on the other hand, appeared to be increasing, especially in women, with some inconsistencies between national and SA data. In both SA and Australia as a whole, death from COPD declined in men but increased in women. The authors call for renewed efforts to reduce smoking rates, and for earlier diagnosis and treatment of COPD.

CANCER SCREENING IN QLD MEN IS NOT EVIDENCE-BASED

Queensland men are much more likely to have had screening via a prostate specific antigen (PSA) test than a faecal occult blood test (FOBT) or a skin check, despite the evidence for PSA testing being the weakest of the three, say Carrière et al (*page 404*). In the Queensland Cancer Risk Study, 2336 men aged 50–75 years were asked if they had ever had a PSA test, FOBT, and/or a whole-body skin examination and, if so, why. Excluding those in whom the test was not considered to be screening, the men were more than twice as likely to have had a PSA test than either of the other two tests. Only 15.5% of men had had an FOBT for any reason.

ANOTHER TIME … ANOTHER PLACE

In 19th century America, the process of grieving was detailed and elaborate. The doctor's letter of condolence was an accepted responsibility and an important part of the support offered to the bereaved … Today, the pattern of mourning has changed.

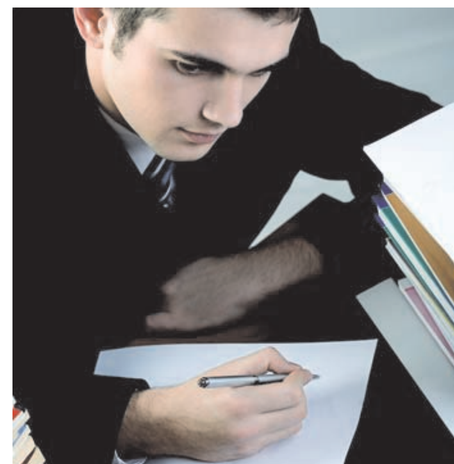
Bedell SE, Cadenhead K, Graboys TB. *N Engl J Med* 2001; 344: 1162-1163

UNDIAGNOSED IEMs CAN BE FATAL

The case of a 44-year-old man who died of hyperammonaemia 8 days after coronary artery bypass surgery illustrates several important points (Chiong et al, *page 418*). Unbeknown to his doctors, the man had an inborn error of metabolism, ornithine transcarbamylase deficiency. Surgery and fasting produced the fatal ammonia build-up, which could have been prevented if the patient's condition had been known before surgery, or suspected when he first developed neurological symptoms after surgery.

LETTERS OF CONDOLENCE

Writing a letter of condolence to the family of a patient who has died is the decent thing to do; it offers closure for the family, the doctor, the practice staff and the medical record; and is good for the soul. So says thoracic and sleep physician, Allen (*page 425*). In today's fast-paced and risk-averse environment, such letters are bound to be rare. Would you write one?



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p387