In this issue

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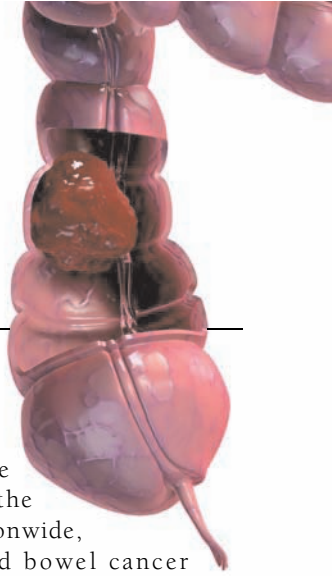

AZITHROMYCIN: WHY THE RUNAROUND?

If you have ever had to take a circuitous route to arrange the correct management for a patient, spare a thought for Bowen and colleagues, who had to deal with the vagaries of the Pharmaceutical Benefits Scheme when a case of pertussis in a health care worker left 62 patients and staff of a paediatric oncology ward requiring post-exposure prophylaxis at the beginning of a long weekend (*page 388*).

ON (AND OFF) YOUR BIKE

Bike-riding injuries are on the rise, but it is unclear whether this is just because more people are cycling, say Sikic et al, after tracking hospital treatment episodes and deaths from cycling-related injuries in Victoria over 5 years (*page 353*). There were 47 fatalities over the period, and emergency department presentations increased by 42%, hospital admissions by 16%, and major trauma by 76%. The authors call for better data on cycling participation, and a comprehensive injury prevention strategy. The news on cycling is not all bad — according to Bauman and Rissel (*page 347*), there is good epidemiological evidence that it confers a significant all-cause survival benefit and, with about a million new bicycles sold in Australia each year, it seems likely that more people are joining the lycra-clad ranks. Initiatives that create an environment in which more Australians can cycle safely will have huge public health benefits across a wide age range.

ENDING ACCESS BLOCK

"Overcrowding has been described as the most serious problem and avoidable cause of harm facing our hospital systems". So begins one of several articles on the problem of access block. Emergency physicians Richardson and Mountain (*page 369*) go on to highlight some home truths about emergency department (ED) overcrowding, for example that it is mainly caused by the need to accommodate acutely unwell admitted patients who are waiting for inpatient beds, and has little to do with low-acuity patients who should be seeing a general practitioner. In a companion article, Cameron et al (*page 364*) offer solutions based on the known causes: reduce demand by providing better care outside hospital, increase the capacity of the ED to deal efficiently with patients and of the rest of the hospital to receive those who require admission, and streamline the processes for safe and speedy hospital discharge. Both articles provide firm evidence on popular strategies that do *not* work, and editorialists Fatovich and colleagues remind us that the health system as a whole must own and address this problem, which causes a great deal of human suffering and a similar number of deaths each year to the national road toll (*page 362*).

If you have any doubts about the human cost of access block, consider the illustrative cases presented in Duke and colleagues' study of intensive care access block in Victoria (*page 375*). A retrospective study of 21 896 admissions to 11 intensive care units and 3039 inhospital deaths over 2 years revealed an average of almost 10 interventions each day to ameliorate access block, including after-hours transfer to a low-acuity ward (18.6% of all ICU admissions), prolonged ED stays (5.1%), postponement of surgery (4.1%), interhospital transfer (2.2%) and premature cessation of intensive care (1%).

MINDFUL SCREENING

Australia is one of the few countries in the world with a nationwide, population-based bowel cancer screening program, and we should strongly encourage all invitees to participate, say Ee and Olynyk (*page 348*). And for patients who are not yet eligible? The same authors make an excellent argument for using the NHMRC-recommended approach of second-yearly faecal occult blood testing and targeted colonoscopy, to make sure that scarce resources are used where they are most needed.

A CONSUMING DILEMMA

Doctors, patients and carers need more information to make rational decisions about gastrostomy tube (GT) feeding, say Calver et al, after completing a study of patients aged ⩾65 years who had GTs placed between 1994 and 2004 (*page 358*). More than half the 2023 patients had a known history of cerebrovascular disease, and paraplegia or hemiplegia, malignancy, and dementia were common diagnoses. Although rates of complications from the tube were low, 54% of the patients died within 1 year of insertion.

BEYOND THE BODY

"It is now time to put into place structures that integrate physical and psychosocial health care", comments Clarke (*page S52*) in the introductory editorial to this issue's Supplement. *beyondblue*: the national depression initiative has joined forces with some leading physical disease groups to rediscover the complex links between healing of body and mind.

Dr Ruth Armstrong, MJA

ANOTHER TIME ... ANOTHER PLACE

It is better not to apply any treatment in cases of occult cancer; for, if treated, the patients die quickly; but if not treated, they hold out for a long time.

Hippocrates (460–375 BC)