In this issue

6 JULY

EVOLUTION OF A PANDEMIC: A(H1N1) IN THE *MJA*

It is only a few months since we first heard that a new strain of influenza was causing severe illness with a high case-fatality rate in Mexico. With the rapid spread of the virus to other countries, including Australia, the *MJA* began publishing information on our website (http://www.mja.com.au) in early May. Information, including testing and treatment guidelines, is being regularly updated on the site. On *page 38* of this issue, the earliest article, an eloquent description of the initial outbreak penned by Canberra infectious diseases physician Senanayake, appears in print.

RESPONDING TO THE FIRES

In February this year, as Australia's worst ever bushfire disaster raged in the rural areas nearby, emergency care planners and hospital staff in Melbourne prepared for the worst. The state had disaster response and mass casualty burns planning in place, with the designated trauma hospitals of the Victorian State Trauma System on alert. A report from Cameron et al (*page 11*), representing the various parties involved, describes the strategic response required to treat patients with bushfire-related injuries over the first 72 hours of the crisis. They conclude that the acute care system was not overwhelmed, partly due to good prehospital care and planning, but also because most victims either died or survived with minor injuries.

BE THE CHANGE YOU SEEK

With this issue comes an invitation from the Australian Commission on Safety and Quality in Health Care to participate in a "conversation" about improving our health care system (*page 7*). Baggoley and colleagues note that there has been plenty of material in the *MJA* of late to inform your ideas, and the current issue is no exception. For those flirting or fighting with the concept of production-line medicine, or "lean thinking", Winch and Henderson contend that what is good for car manufacturers could be disastrous for hospitals (*page 28*); Brooks renews the call for seamless partnerships between academic and clinical medicine (*page 26*); and Newnham et al report on a conference exploring the utility of acute medical assessment units to improve patient care and reduce access block (*page 9*).

NON-INVASIVE *RHD* TESTING

Researchers in Brisbane and Sydney have demonstrated a robust method for assessing fetal Rhesus (Rh) D status — without performing amniocentesis or chorionic villus sampling. Non-invasive testing of fetal *RHD* genotype was developed overseas after the discovery that cell-free fetal DNA is present in maternal serum after about the seventh week of pregnancy. On *page 21*, Hyland et al report the first Australian testing protocol, used on 140 Rh D-negative pregnant women: *RHD* status could be determined in 135 of the fetuses, which proved 100% accurate in this small series when compared with serotyping of cord blood after delivery. An accompanying editorial (Cole and Savoia, *page 5*) raises some exciting prospects for both RhD-negative women (up to 40% of whom will be carrying an RhD-negative fetus and can be spared unnecessary treatment with RhD immunoglobulin) and those at risk of having a baby with other genetic abnormalities, for whom non-invasive genetic testing is on the horizon.

RAISING THE BAR ON TIA TREATMENT

Models of care that allow rapid assessment and management of patients with transient ischaemic attack (TIA) are urgently needed, say Price et al, reporting the results of a National Stroke Foundation survey of the management of TIA in Australian hospitals (*page 17*). Seventy-four hospitals responded to the survey, which revealed that, despite clear evidence that rapid assessment and treatment mitigate TIA patients' high risk of subsequent stroke, only half the hospitals had formalised management policies, and patients at many sites did not receive early access to specialised care.

CASES IN POINT

Along with the research and commentary, there are some clinical gems in this issue. In the ever-changing area of oncology, Chua and colleagues outline their new treatment protocol for peritoneal carcinomatosis (*page 3*), and a *Snapshot* provides a reminder of a painful side effect of the antineoplastic agent docetaxel (Sivaramamoorthy et al, *page 40*). The *Notable Case* (Stuart et al, *page 41*) serves as yet another reminder that tuberculosis has many guises and, in *Letters*, some colleagues from Croatia advise us to keep the lingual tonsils in mind when managing patients with acute, severe sore throat (Janjanin and Prgomet, *page 44*).

Dr Ruth Armstrong, MJA

ANOTHER TIME … ANOTHER PLACE

Epidemics are caused by various kinds of organisms both plant and animal. It is to be noticed that the same law applies indifferently whatever the source of the infection. It applies to the bacilli of plague and enteric fever, to the spirillum of cholera, to the parasites of small pox, probably protozoal, and to those of yellow fever almost certainly protozoal.

John Brownlee, 1908