

This issue of *Critical Care and Resuscitation* tackles a variety of key topics in intensive care medicine. First, it presents the issue of prophylaxis against venous thromboembolism (VTE) in patients with severe traumatic brain injury (TBI). Park and colleagues¹ found that, in a cohort of 100 patients with severe TBI, early VTE chemoprophylaxis (first week) was uncommon. This was despite the almost complete lack of radiological evidence of intracranial haemorrhage after day 3 and relatively frequent pulmonary embolism after day 6. These findings, as discussed in the accompanying editorial,² are consistent with previous data from Australia and New Zealand from the Erythropoietin in TBI (EPO-TBI) randomised controlled trial.³ EPO-TBI showed that Australian and New Zealand doctors applied chemoprophylaxis significantly more conservatively than their colleagues in other parts of the world. Such conservative approach was associated with a doubling in the risk of developing VTE. The reason for this uniquely conservative approach in Australia and New Zealand remains unclear, and this work suggests the need for the intensive care community to focus on improving the quality and timing of VTE prophylaxis in these complex patients.

Another area of relevance is related to the care of patients with large surface burns. In their point of view article, Holley and colleagues⁴ call for the creation of a dedicated data collection and registry for such patients. This would be an important development, mirroring the growing interest in a similar approach in patients with acute liver failure.⁵

In keeping with our commitment to publish protocols and statistical analysis plans for major trials involving Australian intensive care units (ICUs),⁶⁻⁹ Nichol and colleagues¹⁰ present the protocol for the Targeted Therapeutic Mild Hypercapnia after Resuscitated Cardiac Arrest (TAME).¹⁰ TAME is a large trial, which, with 1700 randomised patients, is similar in magnitude to the recent Targeted Therapeutic Management-2 (TTM-2) trial (<https://ttm2trial.org/>). The recruitment for TAME has now been completed, and the 180-day follow-up is currently in progress.

Arunachala Murthy et al¹¹ report the findings of an observational study of current practice in relation to protein delivery in ventilated patients. They found that current practice is to deliver 0.85 g/kg ideal body weight (IBW) per day, a value that is quite different from the estimated

requirement of 1.46 g/kg IBW per day. Moreover, the recommended protein delivery of more than 1.2 g/kg IBW per day was only achieved on 29% of all study days. This study highlights the dissociation between practice and guidelines in this field and provides the necessary background in preparation for a future large trial of usual care versus guideline-based protein administration.

Another field that remains in need of attention and possibly improved practice is that of pressure support ventilation (PSV). Al-Bassam and colleagues¹² report on a unique cohort of patients receiving prolonged ventilation in order to understand the prevalence and management of PSV in such patients. The findings are striking and confirm previous observations in Australia and New Zealand that PSV is a common form of therapy and yet it is prescribed in an adjusted and stereotypical way.

Durie and colleagues¹³ report on the value of the International Severe Acute Respiratory and Emerging Infections Consortium (ISARIC) Coronavirus Clinical Characterisation Consortium (4C) Mortality Score to estimate the risk of death in patients with coronavirus disease 2019 (COVID-19) in Australia and New Zealand. They found that the ISARIC-4C Mortality Score performs poorly in our ICU environment and overestimates the risk of death. This information is important as it can help guide prognostication in the management of COVID-19 in Australian ICUs.

Other brief communications complete this issue of *CCR* by focusing on specific problems, such as the impact of ethnicity on the outcome of cardiac arrest,¹⁴ the demonstration that routine coagulation tests are likely unnecessary,¹⁵ the findings that the measurement of weight in infants has a similar percentage of inaccuracy as in adults,¹⁶ and the estimation of how many in-hospital cardiac arrests may occur in Australian hospitals every year.¹⁷ All provide important epidemiologic information and quality improvement ideas to enhance patient care in Australian and New Zealand ICUs.

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Errata

Duke GJ, Shann F, Knott CI, et al. Hospital-acquired complications in critically ill patients. *Crit Care Resusc* 2021; 23: 285-91. doi: 10.51893/2020.3.OA5.

In this article, on page 290, the Acknowledgements section is missing. It should read: "**Acknowledgements:** We thank the Victorian Agency for Health Information for granting access to the data and permission to publish this research, and to the hospital information managers who collected and entered these data".

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Secombe P, Brown A, Bailey M, et al. Characteristics and outcomes of patients admitted to regional and rural intensive care units in Australia. *Crit Care Resusc* 2020; 22: 335-43. doi: 10.51893/2020.4.OA6.

In this article, on page 338, the heading in the third column of Table 1 is incorrect. Instead of "Rural (6 contributing ICUs)", it should read "Rural (36 contributing ICUs)".

In addition, on page 339, the last sentence in the left column should read "There is some emerging evidence of this, albeit mostly in small single centre observational studies, seemingly suggesting that once admitted to an ICU mortality equivalence exists". On the same page, the first sentence of the last paragraph in the right column should read "The higher frequency of emergency admissions to both regional/rural and metropolitan ICUs are thought to reflect the rates of high risk elective surgery undertaken in tertiary centres (predominantly elective cardiac surgery), and the relatively lower rate of elective post-operative admission diagnosis probably also contributed to the lower rates of mechanical ventilation in both regional/rural and metropolitan ICUs".

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