

What is delirium? How do we diagnose it? What is the difference between delirium and behavioural disturbance? Is delirium a useful clinical construct? Is behavioural disturbance a more useful clinical construct for intensivists? Can we do large-scale epidemiological assessment of behavioural disturbance given that it is not a binary state and that it cannot be diagnosed by numbers? These are fundamental questions in the practice of modern intensive care medicine given that such “states” appear to affect one-third or more of patients admitted to the intensive care unit (ICU). In this issue of *Critical Care and Resuscitation*, we present the first attempt to address this concept using the technique of natural language processing and applying it to electronic ICU notes by nurses, doctors and allied health staff.¹ The findings may surprise you, fascinate you, and make you think about these concepts from a different perspective, as summarised in a thoughtful editorial by Professor Reade.²

However, these are not the only concepts *CCR* explores in this issue. The editorial by Burrell and colleagues³ tackles the concept of ICU efficiency and its graphic representation as is now presented in the Australian and New Zealand Intensive Care Society (ANZICS) updated unit performance format. The special communication section tackles the hot topic of gender equity.⁴ Finally, the point of view article introduces and updates the concept of acute kidney injury (AKI) biomarkers and their meaning and utility.⁵ All three are fundamental reading for Australian and New Zealand intensivists.

Does piperacillin/tazobactam cause AKI (especially in combination with vancomycin) or does it cause “pseudo-AKI”? By demonstrating the interference of this drug with laboratory serum creatinine measurement, Dimeski and

Kruger⁶ raise the possibility that all of the literature on this medication and AKI may simply reflect a laboratory (as opposed to a clinical) event.

Should ICUs provide bereavement support to family members? In a systematic review, Rait and colleagues⁷ provide answers that might surprise many doctors and nurses.

Pulmonary disease and its treatment remains a cornerstone of intensive care medicine. In this issue, we address the characteristics and outcomes of pulmonary oedema,⁸ the importance of distinct acute respiratory distress syndrome (ARDS) phenotypes⁹ and the challenges of understanding the role of higher positive end expiratory pressure in the management of ARDS.¹⁰

The SuDDICU (Selective Decontamination of the Digestive Tract in Intensive Care Unit Patients) trial is fast coming to completion and the protocol and statistical analysis plan of what is going to be a pivotal trial with global repercussions are reported in this issue in preparation for the release of the results early next year.¹¹ On the paediatric front, trial activity is hotting up, and establishing priorities is a key component of the research agenda, as reported by Raman and colleagues.¹²

Finally, a variety of different topics are also presented, which are highly relevant to the specialty from the importance of ventricular fibrillation amplitude¹³ to the ICU cost of facilitating organ donation,¹⁴ and from the role of angiotensin II infusion in the treatment coronavirus disease 2019 (COVID-19)¹⁵ to the international views of clinicians in relation to corticosteroids use in septic shock.¹⁶ The breadth and depth of *CCR* remains outstanding.

Rinaldo Bellomo
Editor-in-Chief

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IN THIS ISSUE OF CCR

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