The issue of optimal dose of renal replacement therapy (RRT) was dealt with by two large trials published 10 years ago, one of which (the Randomized Evaluation of Normal vs Augmented Level [RENAL] of Renal Replacement Therapy)[1] was conducted by the Australian and New Zealand Intensive Care Society Clinical Trials Group. Since that time, the major focus of debate has been around the optimal timing of RRT initiation. As highlighted in the editorial in this issue of *Critical Care and Resuscitation*,[2] this question has already generated three prominent trials, which have shown contradictory findings and had significant design flaws that did not permit the drawing of firm conclusions. In response to this continuing controversy, an alliance of investigators spanning over 160 intensive care units (ICUs) from North America to Europe and from Asia to Oceania designed, and is now about to complete, the largest trial of acute RRT ever conducted: the Standard versus Accelerated Initiation of Renal Replacement Therapy in Acute Kidney Injury (STARRT-AKI) trial.[3] In this issue of *CCR*, we present the protocol summary and statistical analysis plan of what will be a milestone study in intensive care medicine, the results of which are expected to be published next year. Another trial, smaller but also important given current controversy, recently concluded enrolment: the VITAMINS trial.[4] In an important point of view article, Fujii and colleagues[5] highlight the key choice in design which separates VITAMINS from ongoing trials of combined high dose vitamin C and thiamine and stress dose steroids.

In this issue of *CCR*, the Board of the College of Intensive Care Medicine of Australia and New Zealand continues to deliberate and inform the Fellowship on the issue of workforce training and the importance of capacity to train.[6] This is mandatory reading for all Fellows and trainees.

Trauma-associated coagulopathy is a major management problem. It is both plausible and possible that concentrated fibrinogen can positively influence its course. Before large studies are conducted, however, pilot work is necessary to establish its feasibility and biological effect more firmly in the local context. These questions are discussed by Seebold et al[7] in this issue of the Journal. Although it is known that cardiac arrests do occur in Australian hospitals, little is known about their epidemiology and outcome. Jones and colleagues[8] have addressed this problem with a prospective multicentre observational study, which sheds light on the magnitude of the problem and offers multiple opportunities for reflection on how this dramatic complication of hospitalisation might be prevented. Another condition associated with high mortality is severe acute liver failure. In an international first, Warrillow et al[9] organised a collaborative dedicated to understanding its epidemiology in Australia and New Zealand and collected data from all liver transplant ICUs in Australia and New Zealand. What emerges is a picture of different aetiologies between Australia and New Zealand, a dominant non-transplant approach for paracetamol-induced liver failure and, comparatively speaking, high levels of survival despite low use of emergency liver transplantation. The delivery of critical care to Indigenous Australians remains a challenge and has been poorly investigated. In the first step toward correcting such deficiency, Secombe and colleagues[10] provide the first epidemiological analysis of their characteristics and outcomes. Finally, in another first, McEvoy et al[11] tackle a previously unexplored area of intensive care practice: ionising radiation exposure. Once again, in this issue, *CCR* tackles the challenging breadth of issues that affect critical care clinicians in Australia and New Zealand and provides novel insights into our specialty which carry worldwide implications.

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