

This issue of *Critical Care and Resuscitation* focuses on several key aspects of modern intensive care unit (ICU) practice in Australia and New Zealand. Organ donation is particularly prominent, with two original articles and a dedicated editorial.¹⁻³ The first article provides strong evidence that, in more difficult organ donation family conversations (ie, when there is no evidence of organ donation registry presence and organ donation is not raised by the family), the likelihood of successful donation is significantly increased by such conversation being led by an organ donation specialist. As supported by the editorial, it is increasingly clear that in this field, like all other aspects of critical care practice, training and specialisation make a difference. The second article demonstrates that organ donation can be successfully achieved under time pressure, even for highly vasopressor-dependent donors, and with good long term outcome when applying an expedited organ donation process. The implications are clear.

Coronavirus infectious disease 2019 (COVID-19) continues to loom large, with a report on the outcomes of COVID-19 critical illness in Sweden,⁴ correspondence on the use of angiotensin II in ward patients,⁵ and consideration of whether patients with COVID-19 should all be managed in high volume ICUs.⁶

A randomised controlled trial reports attempts to decrease nausea and vomiting in postoperative patients admitted to the ICU by using chewing gum prophylaxis,⁷ an intervention recently shown effective in the immediate postoperative period.⁸ The results are of interest to all intensivists involved in postoperative care.

Is it safe to deliver extracorporeal membrane oxygenation in a low volume centre? How do patients admitted to regional and rural Australian ICUs fare? These questions

are addressed by two important observational studies in Australia.^{9,10} The results support the widespread quality of intensive care management in our region.

Two other observational studies tackle the issue of angiotensin-converting enzyme 2 and acute kidney injury prediction¹¹ and of delirium assessment and management in Australian and New Zealand ICUs.¹² They provide novel insights into biomarkers of acute kidney injury and suggest that delirium care remains imperfect.

Two studies focus on the ecology of ICU management. The first investigates the environment of the ICU with regard to temperature, relative humidity, and light and sound intensity, and describes how profoundly non-physiological the environment is at every level from the normal human circadian point of view, and identifies several aspects of care that can be improved to make ICU ecology more patient-centred.¹³ The second tackles the issue of waste in the form of unnecessary arterial blood gas assessment and demonstrates how, in a large ICU, the introduction of an education program and guidelines results in saving close to \$800 000 and 100 litres of blood over a one-year period without any impact on mortality.¹⁴

Finally, a detailed investigation focuses on persistent critical illness and reports on the complications associated with this condition in 1200 patients.¹⁵ It finds that, while the prevalence of complications is much higher than in other ICU patients, the rate is not, and that some specific complications are particularly prevalent in such patients. These observations open the door to directed interventions in patients at high risk of persistent critical illness.

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