Dispatches from the editor: highlights of this edition

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Johno Breeze^{1,2}

Welcome the third issue of the Journal of the Royal Army Medical Corps (JRAMC) in 2018. As we go to press I have been told the good news that the Impact Factor for the journal has increased from 0.77 to 0.88. For the first time this takes us ahead of our longterm competitor Military Medicine, and we now have the highest Impact Factor of any military healthcare journal worldwide. I would like to thank the members of the editorial board and our colleagues at BMJ for their hard work in achieving this, and in particular my predecessor Lieutenant Colonel Jeff Garner from whom I took over a year ago. As many of you know I have reservations regarding the relevance of measuring the success of our journal using an Impact Factor, but for the time being it remains the primary metric that journals are compared worldwide.

I am currently posted to the USA on exchange and this has given me the opportunity to work with my colleagues in the United States Air Force. This issue contains a paper from my working group looking at the future of training surgeons responsible for treating Head, Face and Neck wounds on deployment. It reflects the reality that multiple specialties of surgeon seen in the civilian environment are unlikely to be present in future military deployments, necessitating the development of extended competencies. It provides recommendations for future collaboration, particularly in the utilisation of fellowships at the completion of surgical training.¹

This issue has three linked papers on the topic of therapeutic cooling and hypothermia and its potential utility in the management of traumatic military patients, a subject of clear interest to our readership. Moffatt *et al*² has published a

systematic review of the literature examining the evidence base behind the use of deep and profound hypothermia in haemorrhagic shock. They identified 19 animal studies demonstrating that hypothermia $\leq 20^{\circ}\text{C}$ can potentially preserve neurological function after prolonged periods of circulatory arrest or minimal circulatory flow. In response I commissioned an editorial from Tishermann *et al* who highlight some of the practical difficulties in actually performing therapeutic hypothermia in the clinical environment.³ I felt that their views are particularly important as they are currently enrolling subjects to the emergency preservation and resuscitation (EPR) for Cardiac Arrest from Trauma Trial at the RA Cowley Shock Trauma Centre of the University of Maryland Medical Centre.⁴ James Collis has also provided a personal view on therapeutic hypothermia focusing more on its potential use in acute traumatic spinal cord. Again he demonstrates some of the limitations in currently published research, particularly animal studies and identifies the urgent need for future clinical trials.⁵

Many readers will know that I continue to champion through the JRAMC original research into wound ballistics, a subject currently going through somewhat of a resurgence with the increasing use of numerical modelling. In this edition Liu *et al* have described their work on the development of a human vulnerability model to assessment bullet effectiveness.⁶ I have provided a commentary to this paper signposting readers to the UK effort in this respect which I'm continuing to undertake with my colleagues from Dstl in between editing JRAMC, not all of which sadly can yet be published in the open literature.⁷ Debra Carr's group continue to undertake the physical research for wound ballistics testing that enables these numerical simulations to be developed in the first place. I highly recommend reading her paper on experimental testing for potential spinal injuries sustained from posterior non-perforating ballistic impacts into body armour

that she undertook with one of my military consultant neurosurgical colleagues, Stuart Harrison.⁸ Finally Ed Barnard and his colleagues from the Academic Department of Military Emergency Medicine have demonstrated that with appropriate and aggressive early management an 11% survival is still possible in military patients who suffer traumatic cardiac arrest.⁹

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¹Academic Department of Military Surgery and Trauma, Royal Centre for Defence Medicine, Birmingham, UK

²Division of Plastic, Maxillofacial, and Oral Surgery, Duke University Hospital, Durham, North Carolina, USA

Correspondence to Johno Breeze, Academic Department of Military Surgery and Trauma, Royal Centre for Defence Medicine, Birmingham B15 2SQ, UK; editor.jramc@bmj.com