
The authors reply

We are grateful for the opportunity to respond to these comments regarding our paper.

With regard to the suggestion that we implied gastric lavage to be an inappropriate measure in scenarios 1 and 2, we must stress that the intention of our paper was to provoke debate (successfully it would appear) rather than to suggest management guidelines.

The paper by Underhill et al (reference 3 above) showed paracetamol levels falling by a mean of 39-5% over the two hours following lavage. This does not demonstrate causality, particularly in the absence of an adequate control group. The paper also demonstrated a mean fall in serum paracetamol levels of 40-7% following administration of ipecacuana and of 92-5% over the same two hour period following administration of activated charcoal.

The difference between results for lavage and ipecacuana was not significant. The fall in paracetamol levels following charcoal was significantly greater than both other forms of treatment. The paper concludes that “activated charcoal was more effective at limiting absorption of paracetamol following overdose than either gastric lavage or ipecacuana induced emesis”. The authors also comment that gastric lavage is not a risk-free procedure.

The new guidelines for the management of paracetamol poisoning recommend lavage or charcoal rather than lavage with charcoal as the optimal treatment within two hours of ingestion (reference 2 above).

Support surfaces

Editor,—I was concerned to read the paper by P W Main and M E Lovell entitled “A review of seven support surfaces with emphasis on their protection of the spinally injured”.

I would not in any way doubt their findings on the pressure problems related to the use of long spinal boards. Unfortunately, however, they seem to have missed the whole point of the use of spine boards in the prehospital care of critically injured patients. Although the spine board may provide a surface for in-line immobilisation of the spine, its primary function is in the road traffic accident setting, where it is used to extricate patients from vehicles and for their subsequent transportation to hospital.

The spine board is the only tool that can be used to slide a patient with a serious injury from a vehicle with safe in-line minimal immobilisation of the spine and retain that immobilisation on route to hospital. With the use of a board for both rearward and side extrication from a vehicle, the patient can be extricated with support to the whole spine safely from virtually any vehicle accident. The board’s construction, specifically designed with a slippery surface to slide patients from the wreckage, has an important advantage over in prehospital care as an extrication device.

This is not possible with a vacuum mattress or scoop types of stretcher or, in fact, any other type of stretcher. The patient on extrication is immediately immobilised with head and neck restraint and four body straps and transferred to an ambulance trolley. The patient is then transported off scene, still being monitored during the short transfer to hospital, where, again, the advantage of being on a board is obvious. In the case of a multiple injury patient, rapid transport from an ambulance to a hospital trolley is essential and this is facilitated by rapid transfer on the spine board, again with a patient fully immobilised. The hospital staff, once appraised of the mechanism of injury and apparent injuries to the patient, can decide whether to maintain the patient on the board or transfer them with an appropriate spinal lift to a vacuum mattress.

If a vacuum mattress is available on all front line ambulances, a single ambulance crew would not be able to transfer a patient, once extricated from a wreckage, from a spine board to a vacuum mattress. The vacuum mattress, therefore, should be considered an ideal A&E department and secondary transfer tool, has a number of practical limitations in its prehospital use as a primary stretcher. The spine board certainly does have its limitations, with pressure area problems if patients are left on the board for long periods of time, but its value as an extrication device, enabling extrication with in-line spinal immobilisation for transfer to hospital, cannot be overemphasised.

This paper clearly emphasises the potential hazards of a spine board to a patient, with defined spinal column injury, but one must remember that the majority of patients are placed on a board with only suspected injury, because of their injury pattern or injury mechanism that dictates the use of a board: does it result in a neutral position of the cervical spine? Ann Emerg Med 1991; 20:876-81.


Fast tracking patients with a proximal femoral fracture

Editor,—Ryan et al are right to highlight the need for improvement in the management of patients with proximal femoral fractures in accident and emergency departments in the United Kingdom but even with the fast tracking system in place, over 75% of their patients waited two hours or more in the A&E department before transfer. Consequently, we feel that the system does not fully address the real priorities for treatment of such patients. We define these priorities as (a) adequate provision of radiographic splintage, (b) prompt imaging and other investigations to allow for a plan of action, (c) the primary prevention of common complications such as pressure sores, and (d) the evacuation of the casualty. We recommend early communication with the patient (and carers) about the likely timescale of transfer to a ward, surgery and postopera-
The authors reply

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