both groups of injuries resulted in a fracture. It is only fractures that were analysed further, and there are two reasons for this. First, especially with children, most accidents causing fractures do result in attendance at an A&E department. Second, case definition is usually straightforward and reproducible. Maitra and Sweeney could thus measure injury rates again after the introduction of a local injury prevention programme and have confidence in their evaluation method. The All Wales Injury Surveillance System (AWISS) is a prime example of this method in action.

The definition of actual rates of injury per child per hour at school or in public places has not been addressed by this study. First, the study was based at one hospital, and neighbouring A&E department records were not accessed. Complete case ascertainment was therefore not possible—the Northern Region has no equivalent to AWISS. It would also be necessary to quantify the relative amounts of time spent by the study population in the various locations. This is useful for certain specific activities, for example, number of miles cycled per cyclist fatality, but is not required in this setting.

The message from this study is that accidents at school generate a significant number of injuries (567 attendances at the Royal Victoria Infirmary in six months), and that these are significant injuries (127 fractures). Therefore, in Newcastle at least, schools are a suitable target for injury prevention initiatives.

MATTHEW Q CHOCYE
Senior Registrar in A&E, Middlesbrough General Hospital

British poison centres’ advice concerning dothiepin overdose in young children

EDITOR.—Two young children aged 1 year 11 months and 2 years 10 months presented with a history of being found with their mother’s 75 mg dothiepin tablets 45 minutes earlier and 24 tablets were missing. Both children were well. The National Poisons Information Service at Guy’s and St Thomas’ were consulted and advised that the children’s stomachs should be washed out under general anaesthetic and repeated doses of activated charcoal be given. This was done and large quantities of chewed tablets were recovered.

In March 1996, a telephone call was made to each of the six British Poisons Centres and up to date advice requested for such cases. The results are shown in table 1. There is agreement that at least one dose of charcoal approximately the child’s age should be given, but advice concerning gastric lavage and multiple doses of charcoal varied. Activated charcoal has a proven role in reducing absorption of tricyclics.8 Multiple doses of charcoal can slightly reduce the half life of tricyclics,9 but there is little evidence that they are effective in toxic ingestions of tricyclics. The effectiveness of gastric decontamination in general is questionable10 and dangerous rhythm disturbances can be precipitated by lavage.

Adult series have shown that only 22% of ingested tricyclics were recovered by gastric lavage.6 No published data are available on the effectiveness of gastric lavage of tricyclics in children. Therefore it is not surprising that the Poison Centres interpret the limited data on multiple doses of charcoal and lavage in different ways and do not give uniform advice. However, the clinician working in accident and emergency must wonder whether it would be preferable for the Poison Centres to have a consensus of opinion on the management of such cases.

D EMERTON
Accident and Emergency Department, North Tees General Hospital, Hardwick, Stockton on Tees, Cleveland TS19 8EP


Homeless people and A&E

EDITOR.—Dr Barnes and his colleagues ought to be congratulated on bringing into focus the A&E care of homeless patients.1 They conclude that there was no significant increase in the use of A&E services by this group during an eight year period. However, more important is that there is not the total use of the service by the homeless but the differing pattern of care required by the homeless compared to home based patients.

A study1 which compared homeless with home based patients attending the A&E department of a teaching hospital in Tyneside found that these patients were predominantly male, unemployed, and less likely to have a GP, had a history of excessive alcohol consumption and involvement with police, and suffered various acute and chronic/minor medical conditions, many of which could have been dealt with by a GP but which also required short term medical admissions. Psychiatric consultations were common but admission to a psychiatric ward rare.

The problems of the homeless should be addressed not in terms of their numbers but in terms of their differing and complex needs, faced by the secondary and the primary care sector.

A K MAITRA
Accident and Emergency, Royal Victoria Infirmary, Queen Victoria Road, Newcastle upon Tyne NE1 4LP

Tropion T in patients with cardiac chest pain

EDITOR.—The use of dry chemistry systems for the rapid measurement of cardiac markers in the diagnosis of myocardial infarction has been advocated.11 As part of a larger trial we looked at the practicality of using the TropT rapid assay system (Boehringer Mannheim UK, Sussex) in a busy accident and emergency department to assess levels of troponin T in patients with a sensitive and specific marker of myocardial damage.

The TropT system is designed to be used both in laboratories and in near patient testing situations. It consists of a plastic slide onto which 150 µl of blood are pipetted into an application well and the slide left for 20 minutes. After this time the reading zone is evaluated. A single line indicates a negative result, two lines indicate a positive with the quoted sensitivity of the slide was < 0.2 ng/ml. Forty one patients attending accident and emergency with cardiac chest pain suspected of having had a myocardial infarct were assessed using the TropT assay, the manufacturer’s instructions being followed in the laboratory. Measurements were made at admission (0 hours), and at 4 and 12 hours after admission.

The following diagnoses were reached in the 41 patients tested: myocardial infarction by WHO criteria (19); angina (10); atrial fibrillation (2); transient ischemic attacks (1); and non-cardiac chest pain (9).

Thirty nine patients tested negative with the TropT assay on admission and two tested positive
Homeless people and A&E.

A K Maitra

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