Management of major trauma

EDITOR,—With major trauma comprising 1 per 1000 emergency cases in Britain there is limited opportunity to develop expertise in the management of this condition. Many of these patients arrive at hospital during unsocial hours when accident and emergency (A&E) departments are often staffed by inexperienced junior doctors. To provide effective initial resuscitation there should be instant availability of experienced doctors from A&E, anaesthesia, general surgery, and orthopaedic surgery as required, and adequate radiology facilities including 24 hour computerised tomography. Unfortunately many district general hospitals are unable to provide an appropriate service from these specialties. The problem is compounded by the general apathy to trauma shown by many senior surgeons. While we would agree with Leaman that all hospitals involved in trauma care should submit data to MTOS, we would not expect the results to be encouraging. Recent analysis of data submitted both to MTOS and to the Scottish Trauma Audit Group showed mediocre results, with delays in treatment despite senior staff involvement in initial resuscitation.

It is obvious that Leaman is not a protagonist of aeromedical helicopter transport; however, in his local region 22% of cardiac arrests are witnessed in the hospital. In 1991, 43% of patients were treated in the hospital with a shockable rhythm, 26% had a non-shockable rhythm, and 26% were already dead on arrival. We would agree that the use of well-trained emergency cardiac teams is important in the hospital setting, although this could not be the reason for the high percentage of cardiac arrests treated in hospital. The factors that explain the difference in MTOS results are not clear, but could be due to the experience of the attending doctors.

We therefore urge that all hospitals be connected to a centralised MTOS registry. This would be a simple task and would improve the outcome of trauma patients significantly. The MTOS registry could also be used to develop a national policy for the management of major trauma.

C MACKAY Accident and Emergency Department, Sally Oak Hospital, Birmingham

K M PORTER Trauma and Orthopaedics, Sally Oak Hospital, Birmingham

Decision support for telephone advice

EDITOR,—We read with interest the paper by Shrimpton et al.1 Since we have been researching telephone advice in A&E and general practice and have developed approaches to standardising patient assessment and advice, we would like to comment on the care of the patient described in this paper.

The patient who was at home with a 68 year old man who was suffering from a few hours of confusion and was suffering from hypoglycaemia. He was treated with a glucose solution and was then transferred to the hospital with a prolonged history of alcohol abuse and recent minor head trauma. The patient’s medical history included hypertension, dyspepsia, and chronic back pain. The patient had a history of diabetes mellitus for 10 years and was on insulin therapy. He was admitted to hospital with a diagnosis of hypoglycaemia and was treated with intravenous glucose solution. The patient was discharged from hospital after 24 hours with a diagnosis of hypoglycaemia and was instructed to follow a diabetic diet.

We would like to comment on the care of the patient described in this paper. The patient was admitted to hospital with a diagnosis of hypoglycaemia and was treated with intravenous glucose solution. The patient was discharged from hospital after 24 hours with a diagnosis of hypoglycaemia and was instructed to follow a diabetic diet.

The patient was discharged from hospital after 24 hours with a diagnosis of hypoglycaemia and was instructed to follow a diabetic diet.

We would like to comment on the care of the patient described in this paper. The patient was admitted to hospital with a diagnosis of hypoglycaemia and was treated with intravenous glucose solution. The patient was discharged from hospital after 24 hours with a diagnosis of hypoglycaemia and was instructed to follow a diabetic diet.

The patient was discharged from hospital after 24 hours with a diagnosis of hypoglycaemia and was instructed to follow a diabetic diet.

We would like to comment on the care of the patient described in this paper. The patient was admitted to hospital with a diagnosis of hypoglycaemia and was treated with intravenous glucose solution. The patient was discharged from hospital after 24 hours with a diagnosis of hypoglycaemia and was instructed to follow a diabetic diet.

The patient was discharged from hospital after 24 hours with a diagnosis of hypoglycaemia and was instructed to follow a diabetic diet.
Treatment of focal status epilepticus with lignocaine.

H Kato, H Kishikawa, S Emura, T Takashima, K Ohmori and H Fujita

*J Accid Emerg Med* 1997 14: 201
doi: 10.1136/ emj.14.3.201-b

Updated information and services can be found at:
http://emj.bmj.com/content/14/3/201.2.citation

These include:
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/