be considered in those patients presenting to an A&E department with features suggestive of migraine.

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The authors reply
The letter from Gupta and Moalypour further illustrates that carotid artery dissection is not as uncommon as had been thought. The range of symptoms recognised as being due to the dissection and any diagnosis will no doubt increase as doctors become aware of it and imaging techniques and access to them improve. At present we are still learning the true incidence and the natural history of this challenging condition.

Minor injuries units
EDITOR,—Mabrook and Dale’s paper on the minor injuries unit in Horsham will doubtless be cited as further evidence of the viability of such facilities. However, closer inspection of their data suggests otherwise.

Firstly, we know that 50% of patients attending minor injuries units could have either self-treated or seen their general practitioner (GP). This implies that only 3472 of the Horsham patients had a significant injury. Of these, 1342 had to be seen by the accident and emergency (A&E) consultant, 234 were referred to the major A&E unit, and 93 were referred to the ear, nose, and throat consultant and radiology departments. This leaves just 1803 appropriate patients who were treated by emergency nurse practitioners (ENPs) during the 12 month period. This equates to 3.5 patients per nurse per working day. A hardly an efficient use of experienced nurses.

Secondly, the paper talks about quality but fails to say whether the ENPs accurately managed soft tissue injuries or whether the antibiotics prescribed were appropriate. Nor are we told how many ENP patients later self-referred to their GP or to the major A&E unit. Nor does the planned readmission rate reported (23%) suggest a particularly efficient or confident department.

As the pressure to close small and medium sized A&E units continues, more and more communities will be offered minor injury units instead. The public should understand that such units are both untested and inefficient of resources.

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The authors reply
The aim of the paper was to evaluate whether an experienced trained nurse can treat minor injuries and ailments in a minor injury unit and not to justify the existence of such units. However, if healthcare trusts decide to commission a unit the year’s study has shown that ENPs can be used to provide a successful alternative service.

The points raised by Mr Leaman are arguments that can be used against the existence of minor injuries units, which might well be valid, however this is not what the authors intended to raise in this paper.

All patients who attended the unit were initially assessed and treated by the ENPs. Patients who were referred to the consultant were patients who required follow up and would have been referred even if they had been treated by a casualty officer. It is true that a high number of patients were reviewed in the unit. This is because the consultant has an interest in the management of the common fractures that do not require orthopaedic intervention.

In order to monitor the ENPs’ work during the year of evaluation, all the patients’ notes were reviewed by the consultant to ascertain whether patients had been diagnosed correctly and treatment had been carried out according to protocols set. Review of patients served to monitor the effectiveness of the treatment given by the ENPs.

As to not having kept a record of how many patients treated by the ENPs then self referred to a GP or an A&E department... is it possible to keep records of this without a national integrated monitoring system? Patients self refer for second opinion all the time regardless of where they have been initially treated.

Risk of fire outweighed by need for oxygen and defibrillation
EDITOR,—We read with interest that Cantello et al from St George’s Hospital have repeated part of an experiment we conducted (at the same institution) examining ambient oxygen concentrations in manikins during cardio-pulmonary resuscitation.1 Unfortunately, it is unclear exactly where their gas samples were taken. They state that “the oxygen level beside the manikin on the trolley surface did rise from 22% at the axilla to 28% 30 cm below the ‘reservoir valve’ but do not define sampling points or the time course of the experiment. This lack of detail may be responsible for Dr Ward’s supposition (in his comments attached to the letter) that Cantello et al measured 28% oxygen concentrations at the axilla. This would be, indeed, a potential hazard as this is a standard paddle position during defibrillation.

We demonstrated a risk of raised oxygen concentrations in areas where oxygen (which is heavier than air) can pool, notably the axilla, when a disconnected ventilation device (Waters’ bag, self inflating bag, and intensive care ventilator) is left resting on the pillow. Oxygen concentrations were not raised if the breathing systems were left connected to the manikin or were removed to a distance of greater than 1 m behind the head. The Air Ambulance Service (UK) “that the breathing system be ... disconnected from and distanced from the patient” sound if the distance be specified as greater than 1 m.

Although ENPs do not have the right to perform defibrillation it is likely that they do apply. It is a simple thing to move the source of oxygen away from the patient in the accident and emergency department. In the intensive care unit respiratory and heart programmes of breathing systems may present more complex problems, it may be safer to leave the patient attached to the ventilator.

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Child Protection Register—in time for change
EDITOR,—The Child Protection Register neither protects children nor is it a good register. It is used in accident and emergency (A&E) departments across the country several thousand times a day as an investigation. What is the sensitivity and specificity of this test, what positive or negative predictive value has it got? Many, if not all, A&E department clinicians

Minor injuries units.

A M Leaman

*J Accid Emerg Med* 1999 16: 77
doi: 10.1136/emj.16.1.77-a

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