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 condition and its 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 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 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. 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 undermanned and inefficient of resources.

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The authors reply
We were pleased to find that McAnulty and Robertshaw's work regarding oxygen concentration during simulated cardiopulmonary resuscitation confirm our research, and are grateful for the opportunity to discuss our methodology in greater detail.

With the manikin and ventilation bag set up as explained in our previous letter, the oxygen level recorded at the sternum and apex paddle positions and also at the mouth remained at 21%. Each position was observed for 10 minutes and the oxygen reading was noted to stabilise after two minutes. Therefore, with the analysers raised above the trolley around the manikin's anterior, there is no change in oxygen concentrations.

Referring to both our earlier letter on the subject and supporting letter by Dr Ward, the real debate is not how far to remove the ventilation bag before defibrillation but whether one should remove the oxygen at all before defibrillation. Which is the greater risk? The risk of fire due to defibrillation over an oxygenated area, or the risk of dislodging the endotracheal tube, reducing oxygen flow to a patient in dire need, and delaying life saving defibrillation?

As a training issue, we concur with Dr Ward, "awareness of the problem is likely to reduce the incidence [of fire]," and Robertshaw and McAnulty, "it is most important to avoid injury by ensuring correct placement of paddles and electrolyte pads before defibrillation...".1

In summary, the risk of fire is remote in properly performed defibrillation; the risks to the patient caused by delaying the time to remove the oxygen, and the possibility of dislodging the endotracheal tube before defibrillation are too great. Whether in the accident and emergency department or the intensive care unit, we reaffirm our belief that oxygen should not be removed before defibrillation.


Child Protection Register—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 tool. 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 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, transferring the patient to a breathing system may present more complex problems, it may be safer to leave the patient attached to the ventilator.

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Minor injuries units.

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Updated information and services can be found at:
[http://emj.bmj.com/content/16/1/77.2.citation](http://emj.bmj.com/content/16/1/77.2.citation)

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**Notes**