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tritrate to gain rapid and effective pain relief.

This policy is adopted by the majority of clini-

cians involved in treating acute medical and

surgical emergencies in our area. The prime

objective of our article was to report excessive

morphine requirements in certain patients who

had received nalbuphine before arrival at

hospital. This phenomenon has been

previously discussed but only as a theoretical

occurrence and had not been reported in

practice. We contend that our experience

merits discussion and additional evaluation of

polices of analgesia administration.

Securing intercostal drains

EDITOR,—The method of securing chest drains described by Boyle using a 1 cm

cylinder of petrol to press the drain provides a simple

technique for adjusting the position of an

intraperitoneal drain.1 However, the commonest

reason for a chest drain “falling out” is that an

inadequate bite of tissue is taken with an

anchoring suture of inadequate tensile

strength. It is not commonly due to poor knot

tying by inexperienced clinicians. As a further

simplification of the method described, if the

chest drain is moved to one end of the chest

wall wound, a single suture (for example a No

1 Ethilon suture on a curved hand held

needle) secured as described by Boyle would

hold the drain in situ perfectly adequately. If

this single anchoring suture were tied flush

thus approximating the skin against the inter-

costal tubing, then any potential air leak at

skin level (should it prove necessary to apply

high flow low pressure suction) would be

obviated. The remainder of the chest

wound can then be closed with simple

interrupted sutures of the clinician’s choice.

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Ectopic pregnancy

EDITOR,—The diagnosis of ectopic pregnancy continues to present a challenge to the

emergency physician as reliance on the standard

history and examination is insufficiently

sensitive. Early diagnosis and referral limit the

morbidity and mortality associated with this

potentially life threatening condition, which

accounts for 5% of all maternal deaths.1 Previ-

ous studies have shown that only 33%–53% of

cases are diagnosed correctly on initial

presentation.2,3 Clancy and Illingworth have

suggested that incorrect diagnoses were made

either because ectopic pregnancy was not

considered or because relevant symptoms and

signs were overlooked.3

Dart et al identified findings in both the his-

tory and physical examination that were

predictive.3 Pain that was moderate to severe,

lateral in location, and/or sharp in nature was

important. The presence of an intruterine

contraceptive device within the previous year,

a history of infertility, pelvic surgery, or tubal

ligation were also noted to be predictive for

ectopic pregnancy. The presence of cervical

excitation, lateral or bilateral abdominal ten-

derness, lateral or bilateral pelvic tenderness,

and positional change were important in the

examination. However no constellation of

findings resulted in a highly reliable diagnostic
tool. The most important of these signs were the

history of tubal ligation (odds ratio 18.0) and the

presence of positive peritoneal

signs (odds ratio 7.9).2

We performed a retrospective case note

review of all patients attending the West Mid-

dlesex University Hospital accident and emer-

gency department between January 1994 and

June 1998 (55 months) in whom an ectopic

pregnancy was subsequently confirmed. We

looked in detail at those in whom there was a

delay before diagnosis, using an evaluation

questionnaire to assess the clinical findings.

Of 109 patients, 70 (64%) cases of ectopic

pregnancy were correctly diagnosed at first

presentation. In the remaining 39 cases (36%)

the most common historical features leading to

a diagnostic delay were the absence of pain

or the poor localisation of that pain. The most

common physical signs were the absence

of cervical excitation and adnexal tenderness.

The most common initial misdiagnosis was

miscarriage.

The diagnosis of ectopic pregnancy con-

tinues to be difficult, mainly because the

symptoms and signs often do not fit a

recognised pattern. In particular the presence

of abdominal pain is considered to be impor-
tant in the diagnosis of ectopic pregnancy, as

is abdominal pain and cervical excitation. Doc-

tors may not consider the diagnosis of ectopic

pregnancy when any one of these features is

absent. The diagnosis must always be con-

sidered in pregnant patients who have yet to have

an intruterine pregnancy confirmed on ultra-

sound scan. It is essential that the presence,

location, and nature of pain is fully elucidated.

In addition, a history of tubal surgery should

always be sought.

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Foreign body in the throat

EDITOR,—A 1 year old baby girl was brought to the accident and emergency (A&E) depart-

ment of Bishop Auckland General Hospital with a history of “swallowing” a ring that she

and her 4 year old sister had been playing with. She had difficulty in breathing with

choking, coughing, and blueness of the face.

She arrived in the A&E department in a

distressed condition with the mother holding

her head down as this eased her breathing.

Radiography of the chest and neck revealed a radio-opaque foreign body (ring) lodged in

the upper respiratory tract (fig 1). Back

slapping and attempted finger sweep of

the mouth and throat was unsuccessful. The

child was kept in the head down position until

a general anaesthetic could be administered

and the ring retrieved from her pharynx.

Figure 1 Radiograph showing ring in the

child’s throat.
The lumen of the ring prevented total airways obstruction and saved this child’s life.

H J B GONSALVES
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Is this a record? Six years in “Paris”

EDITOR.—We should like to bring to your attention an interesting patient who presented recently at our accident and emergency (A&E) department.

The patient was a homeless man, aged 64, who lived rough and was well known in the area. In November 1992 he fell and injured his left knee while under the influence of alcohol. Radiography of his knee showed a simple fracture. The leg was treated with a Dynacast plaster and told to come back in two weeks for review; he failed to keep his appointment.

Almost six years later, in October 1998, the patient arrived in the A&E department, with a request from his general practitioner (GP), to have his plaster removed.

The Dynacast plaster was filthy, foul smelling, but undamaged and it was with some sense of trepidation that the plaster was removed with electric saw. The limb was covered in dead squamous tissue and had four small areas of superficial ulceration. He was able to straight leg raise and to demonstrate about 15 degrees of flexion on removal of the cast. The leg was cleaned and, other than some generalised pallor and thinning of the skin, was found to be extremely healthy. He had very little movement of the knee joint but good range of joint movements. His leg was dressed with mupirocin and a paraffin gauze dressing and then a conforming bandage.

During his six years of wearing his Dynacast cylinder he had walked to Cornwall and to the Midlands, some considerable distances from his home town. In doing so he had lived rough for the majority of that time. In order to move freely he had developed a Parkinsonian type shuffling, which was most effective.

The Dynacast was in excellent condition, as was the stockinet. The wool and other protective dressings, however, were showing signs of degradation. Neither Smith and nephew, makers of Dynacast, nor ourselves, have been able to find any reference to any form of prolonged treatment with a plaster of this nature reported in any of the medical or nursing literature.

There are lessons to be learned from this case. The principal one is the importance of ensuring that when plans in management are altered that records must be altered as well. In this case the patient was seen, or to be seen, by two doctors. As there was no written alteration to the plan on the first attendance at the fracture clinic the second doctor was not to know that the patient was not to be a Dynacast bandage when last seen. It is understood that, because of the nature of his life style, a verbal change of plan was given and a further two weeks in a cylinder was recommended.

Interestingly, the patient decided to remove the plaster as he soon felt that there were too many unpleasant people travelling on the roads.

BOOK REVIEWS

The Midnight Meal and Other Essays About Doctors, Patients, and Medicine.


The Midnight Meal. The very words brought back vivid memories of comforting cheese omelettes, or bacon and beans, eaten with relish in the middle of nights “on call”, waiting for the bleep to go off again. Memories of real food at night, before packaged meals and microwaves on hospital corridors.

In this collection of essays, Dr Jerome Lowenstein, a professor of medicine at New York University Medical Center and a long-time member of the staff of the Bellevue Hospital, writes about some of the changes he has seen in the way medicine is practised, and he reflects on some traditional values, which at times appear to be in danger of extinction.

Many of his essays, such as “Can you teach compassion?” are about a “humanistic” approach to medicine, which he has tried to nurture in his junior staff. He recalls an intern presenting a patient with a five-year-old IVDA and, asking, “Would our thinking or care be different if you began your history by telling us that this is a 35 year old marine veteran who has been addicted to drugs since he served, with valor, in Vietnam?”.

Such attention to patients as individuals is a strong theme throughout. Patients, in Dr Lowenstein’s hands, are not examples of interesting conditions, they are distinct personalities with their own special fears and emotions. “Every patient has a name and a story, yet many seem to remain almost as nameless as patients brought in comatose to the emergency room as ‘unknown white females’” he writes, as he ponders the dilemma between listening to patients, and the pressure to get each one treated quickly and effectively.

Several of his essays concern the patient-physician relationship. “On drawing blood” examines the importance of this simple task in allowing medical students to begin making physical and psychological contact with patients. In “Asymmetry” he discovers, from talking with colleagues, that although in a particular patient-physician relationship there is an asymmetry in the amount of uncertainty, fear, pain, or helplessness felt by the two parties, the physician has to cope with the cumulative effect of repeated “asymmetries”.

Dr Lowenstein takes a look at some of the changes in medicine and medical practice, such as “The biomolecular revolution”, and our increasing reliance on numbers: measuring concentrations and defining treatment thresholds. In “The whole truth . . . ?” he acknowledges progress made in favour of patient autonomy. He does not suggest that we turn back the clocks: the world has changed too much for that, but he does lament the passing of institutions, like the midnight meal, which fulfilled far more than just feeding busy clinicians.

In “Shaky evidence” he takes a playful swipe at evidence based medicine, meta-analyses, and outcomes research, and questions some of their underlying principles. As with the rest of this collection Dr Lowenstein manages to engage the reader with his insights and the deftness of his touch.

This book is not only a good read: it is stimulating and uplifting. It reminded me of my house jobs, the physicians who taught me, and my motives for going into emergency medicine.

BERNARD FOEX
Specialist Registrar in Emergency Medicine, Bolton


Never judge a book by its cover, the saying goes. This book certainly lives up to its outward appearance—the cover is purple and yellow. Historically, both colours are significant—the former adorning Roman Emperors and the latter being revered by the Sun King, King Louis XIV and hence the yellow room in the Palace of Versailles.

I admire the authors for taking on the responsibility to produce such authoritative guidance on such an exhaustive subject. The book is comprehensive yet concise. It is easy to read yet may also be used as a reference book. Many accident and emergency (A&E) senior house officers who use the book as guidance find it extremely useful. It contains facts pertinent and particular to A&E which may only be found in other books either with different or not at all.

The book is also a great time saver in that it contains the latest guidelines and protocols such as the British Thoracic Society guidelines for asthma, and they are all in one easy to find place. It is logical, practical, and well structured.

Where there is pictorial representation, it is done extremely well. This is particularly true in the nerve block chapter (analgesia and anaesthesia).

If I were to suggest any improvements, it would be to highlight in red or italics the critical points—for example, contraindications and pitfalls. It would also be nice to have a small section on a career in A&E medicine.

This is an invaluable adjunct for present A&E senior house officers. The ultimate compliment is to say I wish I had had this book as a junior house officer as it would certainly have reduced my stress levels, in addition to augmenting my medical knowledge.

The book will be valuable to junior doctors, medical students, nurses, and paramedics as well as general practitioners.

I hope we are at the stage when junior doctors can once again begin to say that they have
Foreign body in the throat.

H J Gonsalves

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