should alert A&E department doctors to the possibility of undisclosed domestic violence.

We would like to thank Mr D Bennett for help with statistics and Lynda and Frank at the University of Ulster.

Conflict of interest: none.
Funding: none.


Intercollegiate Academic Board of Sport and Exercise Medicine

The Intercollegiate Academic Board of Sport and Exercise Medicine has been established to function in a role equivalent to a specialist advisory committee on behalf of, and reporting to, its parent colleges and faculties who are full members of the Academy of Medical Royal Colleges. In addition, the board has a category of associate membership for appropriate bodies who are not full members of the academy.

The board plans to develop a higher specialty training programme in sport and exercise medicine which will meet the standards of the Specialist Training Authority and result in successful trainees being awarded a Certificate of Completion of Specialist Training. The board will develop the curriculum, syllabus, regulations, appraisal, and assessment procedures that will act as the basis for a four year Higher Specialty Training Programme in Sport and Exercise Medicine. This will take time but it is planned to have the basis of the programme established by July 2000.

The Intercollegiate Academic Board of Sport and Exercise Medicine believes that the development of this subspecialty interest will help improve the fitness of the nation, the management of soft tissue injuries, and the care offered to individuals participating in exercise for the benefit of their health as well as competitive athletes. The board recognises that these ambitions can only be achieved with the support of a wide range of educational and administrative bodies committed to sport and exercise medicine and hopes to liaise closely with them while developing its plans for the future.

The Intercollegiate Academic Board of Sport and Exercise Medicine can be contacted by writing to its administrative base at the Royal College Of Surgeons of Edinburgh, Nicolson Street, Edinburgh EH8 9DW.

DONALD MACLEOD
Chairman, Intercollegiate Academic Board of Sport and Exercise Medicine

(For full article see British Journal of Sports Medicine 1999;33:73–4)
Sensitivity and specificity of a rapid whole-blood assay for D-dimer in the diagnosis of pulmonary embolism
J S Ginsberg, P S Wells, C Kearon, et al
Annals of Internal Medicine 1998;129:1006–11

Objective—To determine the sensitivity and specificity of a whole blood D-dimer assay in patients with suspected pulmonary embolism and in subgroups of patients with low clinical probability of pulmonary embolism or non-diagnostic lung scans.

Patients—1177 consecutive patients with suspected pulmonary embolism.

Measurements—All patients underwent an assessment of “pre-test probability”, scoring a series of features in the history and examination which allowed identification of groups of patients with low risk (3.4%), moderate risk (26.4%), and high risk (79%) of having a pulmonary embolism. Patients were further assessed by a D-dimer assay, ventilation-perfusion (V/Q) lung scanning, and bilateral compression ultrasonography. Patients in whom pulmonary embolism was not initially diagnosed were followed up for three months. Accordingly, patients were categorised as positive or negative for pulmonary embolism.

Results—Of the 1177 patients, 197 (17%) were classified as positive for pulmonary embolism. Overall, the D-dimer assay showed a sensitivity of 84.8% and a specificity of 68.4%. A total of 703 patients were placed in the low risk group by clinical assessment (pre-test probability of pulmonary embolism of 3.4%). Five of these patients had a negative D-dimer test result and were subsequently shown to have had a pulmonary embolism, a negative predictive value of 99% (post-test probability of pulmonary embolism of 1%, 95% confidence interval 0.3% to 2.2%). The negative predictive value was worse in the moderate and high risk groups.

Altogether 52 of 698 patients with non-diagnostic V/Q scans were shown to have pulmonary embolism (pre-test probability, 7.4%). Of these patients 40 had a positive D-dimer and 12 had a negative D-dimer, giving a post-test probability of pulmonary embolism of 2.8% in the group with a non-diagnostic V/Q scan.

Conclusions—A normal D-dimer test result is useful in excluding pulmonary embolism in patients with a low pre-test probability of pulmonary embolism or a non-diagnostic V/Q scan.

Critique—This study uses a similar approach to the diagnosis of pulmonary embolism as previous work on deep vein thrombosis, and attempts to find a combination of clinical features and investigations to develop a method with a high sensitivity to “rule out” a diagnosis. Firstly a combination of factors from the history and examination are used to stratify patients into groups of varying risk (for example a patient in the low risk group has a 3.4% probability of having a deep vein thrombosis, the “pre-test probability”). A test is then applied to increase the predictive value that pathology is not present (that is to “rule out” pulmonary embolism). Thus in this series if a patient is in the low risk group and has a negative D-dimer then they have only a 1% chance of having a pulmonary embolism (post-test probability). This is as good, if not better, than the combination of a non-diagnostic V/Q scan and negative D-dimer.

There are some limitations to the study as the authors themselves point out. The failure to classify all patients using the current “gold standard” diagnostic test for pulmonary embolism (pulmonary angiography) is a potential limitation when interpreting the results. The whole blood D-dimer assay “SimpliRED” used in this trial was not compared with a laboratory D-dimer assay for sensitivity and specificity. Previous studies would suggest that they are not equally reliable, although there may be practical benefits from a bedside test.

Observer bias was avoided by obtaining the results of the D-dimer assay independently of the pre-test probability assessment and results of other diagnostic tests. For the purposes of the trial, the D-dimer assay was interpreted by a single tester, to avoid any potential interobserver bias, although this assay has been shown to have excellent interobserver agreement and reproducibility.

In 163 of 703 patients in the low risk group the D-dimer was positive but there was no evidence that these patients had a pulmonary embolism, revealing problems with the poor specificity of the D-dimer technique. Therefore in low risk patients with a positive D-dimer some other form of investigation is needed before making a confident diagnosis of pulmonary embolism.

With an overall sensitivity of 84.8% it would be foolish to use D-dimers alone to “rule out” pulmonary embolism, but by combination with clinical assessment, enabling identification of low risk groups, this study does point the way to a more scientific and hopefully safer approach to the assessment of the patient with pleuritic chest pain, an approach that might be possible 24 hours a day, 365 days per year.
The association between seniority of accident and emergency doctor and outcome following trauma
J P Wyatt, J Henry, D Beard
Injury 1999;30:165-8

Objective—This study aimed to provide objective evidence of the way in which the level of seniority of an accident and emergency (A&E) doctor influences outcome after trauma.

Patients and methods—The trauma care delivered in four Scottish hospitals was studied prospectively by the Scottish Trauma Group between February 1992 and December 1996. Criteria for inclusion in the study were those used previously in the Major Trauma Outcome Study. Data were collected on 10 968 patients at hospital presentation from which revised trauma scores and injury severity scores were derived. These scores enabled individual probabilities of survival to be calculated using TRISS methodology.

All those who died of their injuries were included. Details of the most senior A&E doctor involved in treating each patient were prospectively collected.

Analysis—Analysis of actual deaths against expected deaths in the form of a W statistic allowed the management of different cohorts of patients to be compared. Continuous non-normally distributed variables were analysed using the Mann-Whitney U test. Categorical variables were analysed using the χ² test.

Results—The 1208 patients treated by an A&E consultant had a significantly better outcome than the 9195 patients treated by junior staff. This difference in outcome was more exaggerated outside normal working hours. Injury severity scores in the consultant group were significantly higher, revised trauma scores and probabilities of survival significantly lower, and fewer patients spent more than two hours in the A&E department. In addition, patients with major trauma treated by a consultant were significantly more likely to have involvement of consultants from other specialties and be transferred to the intensive care unit than those patients not treated by an A&E consultant.

Conclusions—These results support calls for A&E consultants to be increasingly involved in the management of patients with major trauma. Such increased involvement would require an increase in the number of A&E consultants.

Critique—The aims of the study are important and much of the information is useful. However there are a number of methodological problems that reduce the validity of the main conclusions. There were significant differences in the baseline characteristics of the groups, the junior doctors were seeing older, less seriously injured patients, injured by less serious mechanisms, mainly falls. These are the characteristics of a group of patients who often have important other pre-existing illnesses, which can often have more influence on outcome than the injury. TRISS methodology has no way of allowing for such co-morbidity. The authors could have avoided this problem by calculating the W statistic for only those patients with serious injury. This would have allowed a better comparison of “like with like”.

Indeed they used this type of subgroup analysis for the seriously injured and reported improved process measures, for example as the presence of a consultant reduces the time spent in the A&E department and that consultants from other specialties are more likely to be involved when the A&E consultant is leading the resuscitation. However the evidence concerning outcome should be treated with some caution due to the non-comparability of the baseline characteristics of the study groups.

The prevalence and distribution of bruising in babies
R F Carpenter
Archives of Disease in Childhood 1999;80:363-6

This prospective study of 177 babies attending routine health visitor checks aimed to establish the prevalence and distribution of bruising in babies. There was a highly significant increase in bruises with increase in mobility, highlighting the importance of assessing a baby’s level of development when considering whether a bruise is accidental.

Heading in soccer—time for a rethink?
D P Kernick
British Journal of General Practice 1999;49:171

A recent study found that amateur soccer players had a higher incidence of white matter changes associated with subtle cognitive dysfunction than controls or American football players. The author suggests that allowing heading only in the penalty area would both improve the quality of the mid-field game and eliminate the trauma from long directly returned balls.

Fomepizole for the treatment of ethylene glycol poisoning
J Brent, K McMartin, S Phillips et al for the Methylpyrazole for Toxic Alcohols Study Group

This is a prospective study of fomepizole in the treatment of 19 patients with ethylene glycol poisoning which concludes that, if administered early in the course of intoxication, fomepizole prevents renal injury by inhibiting the formation of toxic metabolites. However, the study has limitations, in that given the morbidity and mortality associated with ethylene glycol poisoning, inclusion of an untreated group was impossible, and the trial was not set up to compare the current standard treatment (high dose ethanol and haemodialysis) with fomepizole.

Cervical immobilisation—are we achieving it?
L Houghton, P Driscoll
Pre-hospital Immediate Care 1999;3:17-21

This prospective study on 24 healthy volunteers showed that currently available cervical immobilisation equipment, although it restricts movement, it does not achieve full immobilisation. No data exist to define how much
movement is sufficient to cause spinal cord damage when there is an unstable cervical spine injury, so ideal immobilisation must be that allowing no movement. However the use of head blocks and straps produces the greatest reduction of movement and the use of collar does not further improve the immobilisation.

Modifiable factors associated with improved cardiac arrest survival in a multi-centre basic life support/defibrillation system: OPALS Study phase I results
I G Stiell, G A Wells, V J DeMaio et al, for the OPALS Study Group
This observational cohort study of 5335 patients who had a pre-hospital cardiac arrest, and were attended by ambulance staff trained to provide defibrillation and basic life support but no pre-hospital advanced life support, indicates that several modifiable factors are associated with improved survival, including bystander cardiopulmonary resuscitation (CPR), as well as first responder CPR by members of the fire service or police.

Influence of cardiopulmonary resuscitation prior to defibrillation in patients with out of hospital ventricular fibrillation
L A Cobb, C E Fahrenbruch, T R Walsh et al
JAMA 1999;281:1182–8
Studies in animals have shown improved outcomes when cardiopulmonary resuscitation (CPR) was administered before an initial shock for ventricular fibrillation of several minutes' duration. Comparing the 42 months of pre-intervention analysis (639 patients) with the 36 months of post-intervention analysis (478 patients) showed that the routine provision of approximately 90 seconds of CPR before the use of the defibrillator, was associated with significantly increased survival, when the response interval was four minutes or longer.

Conservative treatment of displaced fractures of the olecranon in the elderly
L Veras Del Monte, M Sirera Vercher, R Busquets Net, et al
Injury 1999;30:105–10
A small retrospective study that showed good functional results in most of the elderly patients with displaced olecranon fractures treated conservatively.

Is this patient having a myocardial infarction?
A A Panju, B R Hemmelgarn, G H Guyatt, et al
JAMA 1998;280:1256–63
This paper stresses how, despite advances in investigation modalities, a focused history and physical examination, followed by an electrocardiogram, remain the key tools for the diagnosis of myocardial infarction. Following a careful selection of articles from an extensive Medline search, the authors have found that the most powerful features that increase the probability of myocardial infarction are new ST segment elevation, new Q wave, chest pain radiating to both the left and right arm simultaneously, presence of a third heart sound, and hypotension. They conclude that computer derived algorithms that depend on clinical examination, and electrocardiographic findings, might improve the classification of patients according to the probability that a myocardial infarction is causing their chest pain.

The pathophysiology and ICU treatment of patients following the use of ecstasy
P Dobbs
The use of ecstasy and other semisynthetic hallucinogenic amphetamines has exploded during the last decade. This review article highlights the presenting features of ecstasy toxicity, the importance of early supportive management, with the involvement of the intensive care team, and the emphasis on the reduction of body temperature.
A reciprocal arrangement has been set in place with the *Journal of Accident & Emergency Medicine* and *Emergency Medicine* whereby the contents pages of the journals will be published in the respective issues. The contents pages of *Emergency Medicine*, June and September 1999, appear below.

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