LETTERS TO THE EDITOR

Myocardial infarction and left bundle branch block

EDITOR,—We congratulate Edhouse et al on their attempt to try and produce some clarity in the murky waters of diagnosing and treating patients with acute myocardial infarction (AMI), who present with left bundle branch block (LBBB). Unfortunately, we feel that the study has some limitations that could provide for some confusing “take home” messages. There are four points to consider.

1. Schlipak et al,1 which were rightly critical of the cohort chosen and the subsequent extrapolation of results. These views were not adequately reviewed and the “spin” in the discussion by Edhouse et al in our opinion, is overly supportive of Sgarbossa’s criteria.

2. The prevalence of AMI in Edhouse’s and Schlipak’s centers is unusually high for patients presenting to accident and emergency with cardiac sounding chest pain. The method section seems to get that these patients were derived from a database of patients eligible for thrombolysis, which would not be an appropriate study population. This is an important point that requires clarification by the authors.

3. In the conclusion, the first sentence rests on the need for thrombolysing all patients with LBBB and persisting cardiac pain. The last sentence describes some ECGs. It is unclear which side of the fence the authors wish to sit on. The assertion that serial ECGs should be used if “the diagnosis is in doubt” is based upon five patients. We would suggest this recommendation is untenable on the evidence provided.

4. Schlipak et al have published the most robust study thus far (with a more representative prevalence of 28% for AMI) for this group of patients. It is disappointing that this study is not reviewed in more detail by Edhouse et al. The result and conclusions in Schlipak’s paper invalidates any of the Sgarbossa criteria for detection of AMI in the presence of LBBB. They also performed a decision analysis suggesting that an extra 10 to 12 lives per year could be saved by adhering to the American College of Cardiology/American Heart Association guidelines on the subject.2 These recommendations that in the absence of contraindications, thrombolysis should be used in all patients with LBBB who have a clinical presentation of AMI.

Future research strategies using new technologies may herald greater precision and provide the solution for this difficult group of patients. These could include rapid bedside cardiac enzyme analyses, vectorcardiography and/or neural networks. In the meantime we should adhere to the best available evidence.

AMJID MOHAMMED
Specialist Registrar in A&E Medicine

TAJ HAASAN
Consultant in A&E Medicine

WAYNE HAMER
Consultant in A&E Medicine

Leeds General Infirmary, Leeds LS1 3EX


Pedestrian injuries sustained in negotiating traffic calming measures

EDITOR,—We have recently seen two patients who were injured while walking across a traffic calming feature (police box). The first patient, a 56 year old woman could not walk on the pavement as it was blocked by cars. In negotiating the traffic calming feature she lost control of her pram. The second patient, a 73 year old woman, was walking around a police box to get to the other side of the road. She stumbled and fell, cutting one of her
knees. Six months after the injury she has right anterior knee pain caused by the contusional injury. The second, a 60 year old woman, was walking across her road and walked across a parking restraint. She caught her foot and fell forwards onto her outstretched left hand. She sustained an undisplaced distal radial fracture requiring cast treatment.

Sleeping policemen are usually made of the same materials as the road and are usually gently sloping. However, they may be made of different material than the road with different frictional characteristics, they may be sharp, angular and low. It would seem that our patients both misjudged their foot clearance when walking. In both cases the restraints were curved and of the same material as the road, about six inches high. In one case a pavement could not be used. If the restraints are made of a different material to the road surface the friction characteristics may be different and cause difficulties in foot placement and lifting. If they are low and angular they may resemble the ubiquitous raised paving stone. We have heard that these restraints may be inconvenient for emergency traffic including ambulances.

Traffic restraints should be placed in well lit areas of the road, they should have the same frictional or material characteristics of the road, it may be reasonable to place warning notices to take care in crossing these obstructions.

We feel it unlikely that ours are the only injuries caused by this mechanism.

K RAJESH
Registrar in Orthopaedics
M E LOVELL
Consultant Orthopaedic Surgeon
South Manchester University Hospitals, National Health Service Trust, Department of Orthopaedic Surgery, Withington Hospital, Withington, Manchester M20 8LR

Correspondence to: Mr Lovell

Shock and ipsilateral pulmonary oedema

EDITOR,—I had a distinct deja vu phenomenon on reading the article by Desai and colleagues.

In 1970 (30 years ago) David Trapnell and I reported four patients with unilateral pulmonary oedema after pleural aspiration.1 This paper described two patients with pneumothorax but also two with pleural effusions. One of the patients, an 18 year old, died.

The common feature of these four patients was that the air or fluid had occupied the pleural space for some time and were not acute presentations. We concluded “It is established practice in genito-urinary circles to decompress the bladder of a patient with chronic urinary retention slowly. Acute retention is relieved rapidly after insertion of a urethral catheter. We would like to suggest that the same principle of therapeutic relief be applied to the pleural space”. We believed that this important concept had not been reported previously in a group of patients and felt that medical practitioners treating chronic or relatively longstanding pleural effusions or pneumothoraces should be aware of the need to decompress the pleural space with caution.

J G B THURSTON
Clinical Director, Accident and Emergency Department, Joyce Green Hospital, Dartford, Kent DA1 5PL


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K Rajesh and M E Lovell

doi: 10.1136/emj.17.3.233-a

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