LETTERS TO THE EDITOR

Anaesthetic training in accident and emergency

EDITOR,—I read with interest the comments of Boyle et al. regarding anaesthetic training for accident and emergency (A&E) specialist registrars. They suggest that there is a definite advantage in spending six months as a “true” anaesthetic SHO as part of the A&E specialist registrar scheme, rather than as a supernumerary in theatre. As someone who initially undertook a training in anaesthesia with a view to entering higher training in A&E via this route, I would agree that it offers much more than the opportunity to become confident and competent at advanced airway management in the relatively controlled theatre setting. Having spent two years in anaesthesia offers the chance to gain many other skills that are extremely useful to the A&E trainee, particularly in the resuscitation setting, including the assessment and management of critically ill patients, providing ventilatory and circulatory support where necessary, the use of anaesthetic equipment, invasive haemodynamic monitoring techniques and transportation of critically ill patients. The opportunity to become proficient at the various regional anaesthetic techniques and to gain an understanding of pain management is also very relevant to A&E practice.

The possession of the FRCA, which requires at least 2.5 years of training in anaesthesia, is one of the established ways to enter the A&E specialist registrar grade. Surprisingly, in the current membership list of the British Association of A&E Medicine, only 60 (0.05%) members possess the DA (or old primary FRCA), with only 12 (0.01%) possessing the FRCA or equivalent.1 As our specialty continues to develop and accepts more responsibility for early advanced airway management, ventilatory and circulatory support and rapid sequence inductions, both within the A&E department and in the pre-hospital setting, I feel that we should encourage more of our junior trainees interested in a career in A&E to enter the specialist registrar grade via this route.

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Rapid sequence intubation

EDITOR,—All emergency medicine specialists should be competent in rapid sequence intubation (RSI). We thank the authors for their commitment to training this essential skill.1

The simulator experience with video playback could be an extremely powerful teaching aid and a potential attendant complication. Currently, only a few accident and emergency (A&E) departments in the United Kingdom have access to this expensive tool. RSI is a skill that is used with short notice and requires confidence and competence to perform appropriately. The cognitive and psychomotor skills needed are unlikely to be retained from a single course. RSI should therefore be taught as part of an integrated training programme. This should include prolonged exposure to intubations during an anaesthetic attachment, a short course similar to the National Emergency Airway Management Course from the USA covering core knowledge, and a process of revalidation and quality assurance.

We feel that the use of simulators would not be practicable for the primary training of the large numbers of UK A&E specialists in RSI. The use of simulators could, however, play a vital part in the regular appraisal and revalidation of individual practitioners once they have completed their training programme. This revalidation of skills and the regular audit of results should form the basis for the essential quality assurance, which this programme would need.

In summary, if we follow the airline pilot analogy, training occurs in the classroom and in the air, revalidation is the work of the simulator.

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High level simulator

EDITOR,—We were delighted to read of the use of a high level simulator in emergency department training.1

From January 2000, we in the south west have secured three years of funding for the use of the same METI-HPS simulator for specialist registrar training at the Bristol Simulation Centre (www.bris.ac.uk/Depts/BMSC/). Like the Wellington group, we face the challenge of creating realistic scenarios of critically ill and injured patients for the purpose of formative assessment. Clear advantages of the high level simulator over traditional advanced life support group scenario training include:

- real time, accurate audio and video monitoring responses to clinical and pharmacological interventions
- the use of video tape assisted hot review
- interactive physiology and pharmacology tuition, particularly in regards to the use of inotropes, anti-arrhythmics, sedatives, opioids and induction agents.

The additional features available on the METI-HPS were perhaps a little understated in the Wellington paper. Voice simulation is standard, and has particular merit in the resuscitation of a patient in whom a subarachnoid haemorrhage has been diagnosed. In a recent subarachnoid haemorrhage study day run at the Bristol Medical Simulation Centre, the mannequin is also able to simulate needle decompression of a tension pneumothorax (with audible hiss) and successful pericardiocentesis of a cardiac tamponade (with “blood” aspiration). It is able to blink and reproduce unilateral pupillary signs. A child mannequin is available, and a neonatal one is being developed.

On the other hand, at present the simulated wheezing is not convincing in asthma scenarios, and one is being developed.

Like the Wellington study day, the south west simulator programme for trainees is an innovative extension of traditional emergency department training. We see it as an evolving project that will be carefully evaluated from both the trainer and trainee perspective. A further use of this technology already allows online access to live training sessions via satellite cast from the centre via satellite (www.multi-med.co.uk) to user terminals installed at nine hospital sites in the UK.

We would welcome correspondence nationally and internationally.

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1 Harris, et al. Apply Rothrock’s criteria to a UK population of non-trauma patients. Their abstract concludes “Simple criteria cannot be usefully applied to patients presenting to an A&E department in this country to target patients most likely to have clinically significant findings on urgent cranial computed tomography”. We believe that the method and findings of the study do not justify the change in practice implied by this conclusion.

Our methodological concerns are threefold. Information gathered retrospectively from notes and request forms casts doubt over the accuracy and completeness of the symptoms and signs (particularly the symptom of nausea). The inclusion criterion is ill defined (patients who are referred for cranial computed tomography). There is no explanation for the inclusion of nausea (it is not one of Rothrock’s original criteria).

There are also theoretical objections. To be useful, a clinical filter must be applied to unselected patients and include criteria that have a high inter-observer reliability. There is no logic in applying a clinical filter after the decision to investigate has been made.

Furthermore, both studies acknowledge that they do not tackle the problem of subarachnoid haemorrhage in young patients presenting with isolated headache. Surely this is a major consideration in formulating any criteria for computed tomography (CT)?

We applied Harris’ criteria to our prospective series of patients attending A&E with non-traumatic headache (248 patients). Seventy-two CT scans would have been performed. The criteria would have missed three (1.2%) patients with an abnormal CT scan.

J Judging from the differing rates of CT abnormality in the two studies (35% v. 6%), CT rates in the UK are well below those in the USA. Given that we accept a detection rate of 1 of 80 for patients with skull fracture and GCS 15, perhaps we should be scanning more patients with non-traumatic headache not fewer.
The authors reply

Our modified criteria are simple, common-sense suggestions that reflect current practice regarding requesting CT from the accident and emergency department. We acknowledge the retrospective nature of our trial. Having now demonstrated that the criteria could be useful, prospective validation is necessary.

HELEN DRAPER
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The irritable hip

EDITOR,—As Mattick et al explain, the irritable hip is a common presentation that requires the exclusion of serious pathology. The protocol described allows appropriate outpatient management of many children. The text describes how no one single investigation or examination finding is predictive of septic arthritis. We were however disappointed to see a “blanket” approach to investigations with all children undergoing blood tests. History and examination are more useful than any investigation. If a child has been unwell, whether feverish or not, septic arthritis should be considered and appropriate investigation and treatment instituted.

Furthermore, in a well child with an isolated painful hip, structural problems need to be excluded with imaging but we have not found blood tests helpful. These are the factors that we use in the individual evaluation of a child with a painful hip in our emergency department.

We appreciate that the comprehensive approach by Mattick et al is aimed at detecting serious disorders but do not agree that blood tests are necessary for every limping child.

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Topical anaesthesia use in the management of children’s lacerations, a postal survey

EDITOR,—The suturing of lacerations of children is often difficult. Infiltration with 1% plain lignocaine (lidocaine) is commonly used to make the suturing procedure more comfortable. This infiltration may cause pain and render the child uncooperative for the rest of the procedure. Topical anaesthesia (TA) has been described since 1980.2 The agent commonly used is a mixture of 0.5% tetracaine, 0.05% adrenaline (epinephrine) and 11.8% cocaine (TAC). This method has a similar efficacy to infiltration but is less painful to apply3 and is used widely in the United States. All 597 accident and emergency (A&E) departments in the UK were sent a questionnaire about their use of TA in children’s lacerations. There was a 71% response rate. Of the 34% of all respondents who used TA, 33% used Emla, 31% used lignocaine and 26% used Arteloc. Less than half of these felt TA was preferable to injection. Only 8% used cocaine and adrenaline mixture but 91% of those preferred it. TAC was used in 3%. Most (66%) departments did not use TA. There were many reasons given. The commonest reasons were “no experience” (28%), “TA ineffective” (20%), “slow onset” (10%) and “department protocol” (10%). These are the postcard surveys sent to a sample of 110 respondents selected from the total list.


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This survey has shown that only a minority of UK A&E departments use TA for suturing children’s lacerations and, of these, few use agents for which there is evidence. TAC use has been associated with prolonged fitting1 and mortality;1 is expensive and contains a controlled drug. The rare catastrophes to-
Feigning dystonia to feed an unusual drug addiction

Editor,—We recently had a patient attend our department repeatedly feigning acute dystonia in an attempt to obtain procycli

dined. He made a recovery within a few minutes and was discharged.


NOTICES

13th Annual Congress of the European Society of Intensive Care Medicine

1–4 October 2000, Rome, Italy

Further details: ESICM Congress Secretariat, 40 Avenue Joseph Wybran, 1070 Brussels, Belgium (tel: +32 2 559 03 55, fax: +32 2 527 00 62, e-mail: public@esicm.org, web site: http://www.esicm.org).

Books received


Clinical Toxicology Short Course

30 October to 8 November 2000, Adelaide, Australia

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