LETTERS TO THE EDITOR

Fireworks related injuries: does changing legislation make a difference? A thought for next Hallowe’en

EDITOR,—In August 1996 there was a change in legislation. The Explosives Act (Northern Ireland) 1970 (as amended by the Explosives (Amendment) (Northern Ireland) Order 1996) allowed over the counter sale of fireworks to anybody over 16 year of age. Prior to this, it was illegal to buy fireworks in Northern Ireland.

For the same four week period (11 October–11 November) for the years 1994 and 1995, all accident and emergency notes were reviewed retrospectively and patients with fireworks related injuries were identified. The years 1996–1998 were collected prospectively. The patients’ sex, age, date of presentation, injury, site of injury and follow up were recorded.

Thirty five patients presented to the department with fireworks injuries over the study period. This consisted of 27 men and eight women (fig 1). Men in their late teens (mean age 18 years, 77% of all males) were the predominant group. Fifty five per cent of all injuries involved the hand. The authors state in their conclusions that the majority of accident and emergency (A&E) consultants thought that rapid sequence induction (RSI) would be undertaken by A&E staff if an anaesthetist were unavailable. If the A&E staff are only performing this procedure rarely then they will become de-skilled and will have a higher complication rate than a colleague performing the procedure on a regular basis. Anaesthesia is defined as an essential secondment for training, why have this secondment if the skills are not going to be actively used.

In order to be given the responsibility of “on call” the anaesthesia minimum requirement is three months of supervised training. I feel that it is no coincidence that this also is the length of our secondment.

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1 The Explosives (Amendment) (Northern Ireland) Order 1996

Survey of the use of rapid sequence induction in the accident and emergency department

EDITOR,—The paper by Walker and Brenchley highlights a crucial area of emergency medicine practice. Medicine practice issues are “How are skills maintained” and “What is an acceptable period of training”.

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Survey of the use of rapid sequence induction in the accident and emergency department

EDITOR,—As a doctor with a background in both anaesthesia and accident and emergency (A&E) medicine, and currently working in an emergency medicine environment, I read the paper by Walker and Brenchley with interest. I have been aware for some time now of the debate among emergency physicians, and anaesthetists, over their respective roles in emergency airway management. I suspect that anaesthetists are probably guilty of being of blind and territorial, and somewhat condescending, over the issue. However, I am also aware that among emergency physicians there is a slightly concerning “gung-ho” element to their approach to this procedure, which I believe betrays a lack of understanding of the technique, and of the risks involved. In illustration of this, I remember seeing in an A&E department of a hospital I have worked in, the abbreviation RSI expanded to “rapid sequence intubation”.

The use of RSI of anaesthesia to facilitate intubation of the trachea is an inherently risky technique. So that the risk of regurgitation and aspiration is minimised, the patient is paralysed before control of the airway is assured. Furthermore, unlike in any other anaesthetic technique, the drugs used are given as a rapid bolus of a predetermined dose. These agents have real potential for causing harm if the dose is not precisely and accurately administered. Thus it is essential that A&E staff can do this competently and completely. Regular and routine practice of RSI will help prevent skill deterioration as will the use of patient simulators for airway training as described by Ellis and Hughes. Hence, A&E

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Editorial comments

I read with interest the article by Walker and Brenchley regarding the use of RSI by accident and emergency (A&E) medical staff.¹ Emergency medicine is characterised by the ABC approach with airway management as the first priority, which by definition includes performing RSI where necessary. This is not to say that A&E staff can do this competently and completely. Regular and routine practice of RSI will help prevent skill deterioration as will the use of patient simulators for airway training as described by Ellis and Hughes. Hence, A&E
Letters to the editor

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Intranasal midazolam. An alternative in childhood seizures

Editor,—The fitting child is a common problem presenting to the emergency department. Prolonged fitting is potentially harmful and early treatment of seizures may reduce actual mortality and morbidity. The gold standard against which new treatments have to be compared has been rectal diazepam or intravenous lorazepam.

Obtaining intravenous access in a fitting child can be difficult. The rectal route has been successful both in hospital and before hospital admission. There are however difficulties with this route: absorption may be variable and non-medical staff may be reluctant to administer rectal drugs.

Recently interest has been shown in the use of midazolam administered via the buccal route to treat fits in the prehospital environment. It was shown to be efficacious and safe though no significant reduction in time to seizure cessation was found in comparison with rectal diazepam. A further trial set in an emergency department compared intranasal midazolam (0.2 mg/kg) with intravenous diazepam. Time to seizure control from admission was found to be less in the midazolam group.

Midazolam via the intranasal route has been successfully used for pre-procedural sedation of children and has confirmed anti-epileptic properties. Indeed EEG evidence of anti-epileptic action within two to five minutes of intranasal administration of midazolam has been demonstrated.

We have successfully used intranasal midazolam on two fitting paediatric patients who proved difficult to obtain intravenous access. The dose chosen was 0.5 mg/kg; one that has been used successfully for procedural sedation with no respiratory compromise.

CASE 1
A 15 month old male epileptic had been fitting for two hours before admission despite administration of rectal diazepam (2 × 5 mg). He was given 0.5 mg/kg intranasal midazolam. Fitting stopped within five minutes of treatment.

CASE 2
A 3 year boy had been fitting for 15 minutes. Fitting was seen to stop within 2.5 minutes of administration of 0.5 mg/kg of intranasal midazolam. No patient suffered any respiratory depression, or any other adverse effects.

We feel that the intranasal administration of midazolam warrants further evaluation as a treatment of the fitting child.
Intranasal midazolam. An alternative in childhood seizures

Ray McGlone and M Smith

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