Lack of change in trauma care in England and Wales since 1994

We read with interest the article and accompanying editorial by Lecky et al.1 Of note, between 1989 and 1994 there was an increase in the proportion of trauma patients (15% to 15) in whom a consultant was involved in their care at the same time, trauma-related mortality fell. Since then, both the level of documented consultant involvement and the mortality have plateaued. Documented middle grade involvement is unchanged from 1989.

This lack of improvement in the involvement of consultants and middle grades is of concern, and there is great pressure from many sides to increase senior cover on the shop floor. This includes BAEM and FAm:1 of the main recommendations of this paper is that shop floor consultant cover should be available 12 hours a day, 7 days a week. This is to achieve the objective of allowing all patients to have an experienced clinician (specialist registrar, non-consultant career grade, consultant) either care for them directly, or supervise their care closely. Providing it is not libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on "read eletters" on our homepage. The editors will decide as before whether to also publish it in a future paper issue.

Table 1

<table>
<thead>
<tr>
<th>Triage</th>
<th>Total number of patients</th>
<th>Number (%) of patients</th>
<th>Seen initially by experienced doctor</th>
<th>Seen during visit by experienced doctor</th>
<th>With experienced doctor involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20</td>
<td>2 (10)</td>
<td>13 (65)</td>
<td>13 (65)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>163</td>
<td>32 (20)</td>
<td>46 (28)</td>
<td>59 (36)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>502</td>
<td>124 (25)</td>
<td>174 (35)</td>
<td>219 (44)</td>
<td></td>
</tr>
<tr>
<td>4 and 5</td>
<td>1304</td>
<td>337 (26)</td>
<td>381 (29)</td>
<td>418 (32)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1989</td>
<td>495 (25)</td>
<td>614 (31)</td>
<td>709 (36)</td>
<td></td>
</tr>
</tbody>
</table>

*Consultant, SpR, or NCCG.

References


Author’s reply

I read the response from Walls and Guly with interest. From the study they describe it is clearly possible that the level of senior doctor involvement is underestimated on the TARN database because of a failure of notekeeping. However, there is no reason to suspect that failing to record senior doctor involvement would be more prevalent in 2000 than in 1989 therefore there should be no systematic bias in our trends analysis.

More importantly, the failure to record senior doctor involvement may be one reason why there is no significant outcome difference in the patients “seen” by different grades of doctor (according to their notes)—figure 5 of our article.

It is probably advisable for all senior doctors to record any involvement they have had with patients—even just the giving of advice—in the notes. As well as satisfying clinical governance requirements this will improve our ability to examine future trends in trauma care.

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Reference

Use of anti-D immunoglobulin in maternal trauma

We read with interest the article by Weinberg that revealed a lack of awareness among accident and emergency (A&E) staff of the risks of rhesus sensitisation as a consequence of threatened miscarriage. Similar findings were reported in previous studies on anti-D immunoglobulin use in A&E. This problem also exists in cases of maternal trauma in early pregnancy. We conducted a telephone survey of A&E SHOs in the North West region. A clinical scenario was given of a patient of 18 weeks’ gestation with closed abdominal trauma due to domestic violence. SHOs were asked regarding their management of this case. Sixty two responses were obtained. The possibility of rhesus alloimmunisation was identified by 19 (31%) doctors. Three of these 19 would request a Kleihauer test while the remainder would check maternal rhesus status. If rhesus negative, nine would give anti-D immunoglobulin in the A&E department. The other nine SHOs would refer the patient to the obstetricians on call for further evaluation. Our survey then prompted the remaining 44 doctors with regard to rhesus incompatibility by bringing to attention previously documented rhesus negativity in the patient’s case notes. Equipped with this knowledge, only eight doctors would then give anti-D immunoglobulin in A&E, while 11 would refer the patient for this purpose. Even then, need for anti-D immunoglobulin was still unrecognised by 25 of 44 (57%) SHOs. Our study is in agreement with the author's findings that guidelines for rhesus sensitisation, without doubt, is the difference. 

Tissue adhesive with adhesive strips for wound closure

Mattick et al report their comparison of tissue adhesives and adhesive strips and describe them as equally effective “no-needle” alternatives for the closure of suitable paediatric lacerations. Previous reports in the literature include a controlled trial comparing sutures, tape, and octylcyanoacrylate tissue adhesive for skin closure by Shamiyeh et al that showed no significant difference between the methods, but a comment that scars tended to be slightly wider in the no-suture groups. Quinn et al conducted a randomised trial comparing octylcyanoacrylate tissue adhesive and sutures and found the management of lacerations, again showing no significant cosmetic difference. The use of tissue adhesive and adhesive strips for wound closure is now common place in many emergency departments, though each have their limitations and practical difficulties. I wish to describe a simple technique of the combined use of these two methods for wound closure. An example scenario for this technique is where a wound can be manually held together with little tension but where there is concern that wound edge separation may occur after initial closure.

The wound edges are approximated and then held with one or more adhesive strips. The wound is then be reinforced by application of the tissue adhesive between and over (through) the adhesive strips. Alternatively, a wound that will not stay closed initially with adhesive strips alone may be closed by application of tissue adhesive to the underside of one end of an adhesive strip, allowing this to adhere to the skin on one side of the wound, before sticking the other end down in a similar manner holding the wound closed. The wound edges can be reinforced with further strips or tissue adhesive as previously described.

I have found this method, initially seen in Belfast, Northern Ireland, to be extremely useful in securing wound closure efficiently and painlessly, especially in children.

R Eager

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References

Tissue adhesive with adhesive strips for wound closure

P Atkinson

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