lines, with the exception that it occurs daily, instead of weekly. I found in my review of this clinic (Finlayson et al., 1986), that it served a very useful purpose in reducing morbidity from hand injuries, ensuring early and correct definitive treatment of hand injuries and in teaching the Casualty Officers about the management of such injuries. A daily Hand Injury Review Clinic also runs in the A&E Department at Queens Medical Centre.

I would like to recommend that clinics such as these should be more widespread.

BRUCE FINLAYSON
Accident and Emergency Department,
Queens Medical Centre,
Nottingham, England

REFERENCE


Thrombolytic therapy for myocardial infarction—our role

Sir

Thrombolytic therapy may be a major advance in the treatment of myocardial infarction (MI) and accident and emergency (A&E) should become a key service when it becomes accepted practice (Smith & Eisenberg, 1987).

The logic of thrombolysis is:

(1) 85% of transmural myocardial infarctions are caused by thrombosis or an atheromatous plaque (Smith & Eisenberg, 1987);
(2) the clot can be lysed by streptokinase, tissue plasminogen activator or acylated plasminogen activator (DeWood et al., 1980); and
(3) the myocardium can resume function if it is reperfused within 6 h (DeWood et al., 1980).

A number of clinical studies indicate that thrombolysis can reduce the early (21-day) mortality from MI by one fifth, if it is started within 6 h of onset of pain (Kennedy et al., 1985; TIMI, 1985). If started within an hour, the early mortality is halved. This reduced mortality continues for a year (GISSI, 1986). Those persons under 65 developing their first anterior infarct on ECG, seem to benefit most. Intravenous streptokinase in a loading dose followed by infusion up to a total of 1·5 million units over an hour is commonly used. Minor problems of bleeding, hypotension and allergy are noted.

In the next 5 years, thrombolysis will gain further acceptance. It is crucial that the A&E department is seen to be able to respond rapidly with trained staff in well-equipped resuscitation rooms. The patient with chest pain can be monitored, the parameters for starting thrombolysis identified (for example, ST elevation) and the intravenous therapy commenced within minutes of arrival.
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As A&E departments are getting used to medicine by protocol, they will be in a good position to offer a prompt service for early administration of the thrombolytic agent. They should resist any suggestions of patients with chest pain bypassing them on their way from the community to the coronary care unit (Richards, 1987). Although this suggestion may be implemented in a few places, it is unlikely that the average CCU would be able to cope with the large number of false positive cases (Tachakra, 1987). Also, the tacit assumption that a certain number of false positive cases will be treated should be avoided. Just as defibrillation, now hailed as the biggest advance in the management of MI, is being taught to ambulance crews, so, 10 years from now, thrombolytic therapy may be started by ambulance men and paramedics.

S. TACHAKRA
Accident and Emergency Department,
Central Middlesex Hospital,
London, England

REFERENCES


Lower limb skin loss: simple outpatient management with meshed skin grafts with immediate mobilization

Sir

Messrs Shankar & Khoo’s paper advocating the use of mesh skin grafts and out-patient management of minor lower limb skin loss (Archives of Emergency Medicine 4, 187–92) is an advance in the management of this condition. However, it would seem unnecessary to inflict a further wound on the patient in the form of a donor site, when the traumatized skin should itself be used as the skin graft. If the injury is fresh, this skin should be viable. That this is often the case was demonstrated by King (1987). With a little ingenuity, the excised skin can be defatted or shaved of its underlying layers, to provide a thin Wolfe graft or split skin graft, as was described by McGRouther & Sully (1980) for very large lower limb degloving injuries.
Thrombolytic therapy for myocardial infarction--our role.
S Tachakra

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