based doctor (Heeley J., personal communication, 1991). Studies in the U.S.A. have shown that paramedics can set up a drip in under 3 min with a first time success rate of 90% (Pons et al., 1988, Jones et al., 1989). The first of these studies also demonstrated that iv’s could be commenced just as quickly and successfully whilst in transit. Early initiation has the advantages of easier insertion, earlier commencement of therapy and prevention of shock as opposed to its treatment. It is apparent that protocols need to encourage the use of larger volumes of fluid in cases of trauma and to encourage IV insertion whilst in transit. In the A&E departments we need to assist paramedics in becoming experts in iv cannula insertion.

It may be possible to prevent unnecessary delay by setting time limits for individual procedures related to time from hospital, anatomical severity of injury and the patient’s physiological parameters. The availability of advice for the paramedic, via radio link, from a doctor experienced in resuscitation could prevent unnecessary delay and ensure more appropriate fluid therapy; any attendance at the scene should be used for educational as well as treatment purposes.

Until analysis of survival of patients treated by paramedics, technicians and basic crews is undertaken using accepted techniques, such as TRISS (Boyd et al., 1987), it cannot be stated that pre-hospital management by paramedics may be jeopardizing patient care.

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REFERENCES


Seat-belt injury

Sir

The X-ray (Fig. 1) shows another injury caused by a three-point safety belt (Salam et al., 1991) – an isolated fracture of a right cervical rib. This 51-year-old driver had suffered no symptoms referable to cervical ribs prior to the accident. She had
Fig. 1. Diagram and radiograph showing an isolated fracture of a right cervicle rib caused by a three point seat-belt.

a typical seat-belt bruising pattern over the right side of her neck, chest and abdomen. Apart from some discomfort in the immediate post injury period, she has suffered no complications since (1 year later).

Cervical ribs are present in 0.46% of the population and are asymptomatic in 90% of individuals (Bailey & Love, 1981).

Complications of intact cervical ribs, the thoracic outlet syndrome and fractures of first ribs are all well described, but fractures of cervical ribs appear to be very rare, only two previous cases having been traced in the literature. Andriev (1951) described a case of Raynaud’s disease caused by the fracture of an accessory cervical rib, and Du Toit (1982) presented a case in a young woman which led to neurological complications.

Isolated first rib fractures may be caused by direct trauma, indirect violence caused by contraction of scalenus anterior or serratus anterior, or by chronic stress. Du Toit (1982) postulated that a cervical rib could only be fractured by direct trauma because of its position and lack of muscular attachment.

Many injuries may have been incorrectly attributed to the wearing of seat-belts (Newman, 1984), but shoulder restraints have caused simultaneous and opposite first rib fractures in a front seat passenger and driver (Kaye, 1984). The pattern of bruising seen in this case suggests that the cervical rib fracture was caused by a similar mechanism of injury. This has not been previously recorded.

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REFERENCES

Rare diseases do occur: an acute presentation of Huntington's Chorea

Sir

Huntington's Chorea is an uncommon disease with a worldwide prevalence of 5–10 per 100 000 (Hayden, 1981). It usually presents to the general practitioner, psychiatrist or neurologist. Recently with the advent of biochemical predictive testing, individuals at high risk are screened.

A 43-year-old man was brought to an A&E department by his two employers (for whom he worked as a gardener), late one evening. The employers complained that over the past 4 months the man had become increasingly listless, apathetic and his cerebration had become dulled but could offer no explanation for the urgency of the consultation. The patient himself had not noted these symptoms but he has noted that he could not always 'control his limb movements'. He had a family history of an obvious autosomal dominant inherited disease characterized by dementia, movement disorder and early death (for which his family in Jamacia had never sought medical advice).

Examination of cardiovascular, respiratory and abdominal systems were unremarkable. Examination of his nervous system demonstrated choreiform movements which were more marked in his face and upper limbs and an odd gait with repeated standing on his toes. At this time a presumptive diagnosis of Huntington's Chorea was made and the patient referred for psychiatric and neurological appraisal. Psychiatric assessment showed him to be apathetic but to have no obvious signs of dementia at the time of examination.

Investigations revealed immunological signs of treated syphilis, a normal serum copper and a CT scan of the brain showed reduction in volume of the head of the caudate nucleus and dilatation of the lateral ventricles (changes considered to be pathognomic of Huntington's Chorea).

The diagnosis of Huntington's Chorea was made, he was offered genetic counselling and his children were offered further genetic studies. He was treated with Tetrabenazine which improved his chorea. One year subsequently he was lost to follow up.

A full literature search has revealed no examples of emergency presentation of Huntington's Chorea. We believe that this is the first person to have presented 'acutely' to an Accident and Emergency department with Huntington's Chorea.

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