Short reports

Longstanding periorbital foreign body

A case of an unsuspected long-standing periorbital foreign body is presented and the appropriate investigations and management are outlined briefly.

A 43-year-old woman attended the accident and emergency (A&E) department having sustained some contusion of the left forehead and eyelids whilst intoxicated by alcohol. She had no recollection of the circumstances of her injury. Her only symptom was of mild discomfort in the region of the bruising and clinically there were no orbital signs, but plain facial radiography revealed a large left periorbital foreign body (Fig. 1). An unsuccessful attempt was made by the A&E registrar to extract the object per nasum. The following day she attended the ophthalmology clinic where, on detailed questioning, she recalled that 11 years previously one of her children had inserted a disposable ball-point pen

Fig. 1. Radiograph demonstrating large left periorbital foreign body.

into her nose. She had retrieved the pen herself, sustaining a minor epistaxis, but was unaware that the metallic end-piece of the pen had been retained. A full ocular and orbital examination failed to reveal any abnormal signs. Since no ill-effects had arisen from the foreign body, no treatment was recommended.

The decision to proceed with surgical removal of such foreign bodies in the absence of a penetrating ocular injury or entry into the cranial fossae depends on the composition of the material and the functional sequelae of its presence. Indications for attempted removal are a reduction in visual acuity, signs of optic nerve compression, globe displacement (proptosis or enophthalmos) and ophthalmoplegia.¹ Pre-operative localization is best performed by computerized tomography (CT) which is superior to ultrasound.^{2,3} It should be remembered that magnetic resonance imaging (MRI) is contraindicated in the presence of a metallic foreign body which may move and further damage introrbital structures.⁴ In general, metallic foreign bodies become rapidly encapsulated and are well-tolerated but organic particles tend to lead to suppuration, fistula formation or extrusion although this may sometimes be delayed for many years.⁵ Conservative management is often the most prudent approach as surgical intervention may result in far more serious complications than would have arisen during the natural course of events.¹

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The Patient's Charter: views of patients attending an inner-city accident and emergency department

SUMMARY

We conducted a prospective study of patient's understanding of the Patient's Charter. Every patient attending the Accident and Emergency (A&E) Department of St Bartholomew's Hospital over a 7-day period was questioned by an interviewer. Those not interviewed by this process were sent a postal questionnaire. A total of 584 patients attended during the study period, from whom 451 data sets were collected, a response rate of 77%. Only 51 patients were aware of The Patient's Charter guarantee of 'immediate assessment'. When asked what they understood by 'immediate', 67% of respondents considered this to mean 15 min or longer. Fifty-four per cent of respondents felt that this assessment should be performed by a nurse. A follow-up study conducted over a 48-h period in January 1994 showed no significant difference in the responses to the same questions.

We conclude that the vast majority of patients in this study exhibited a very low level of awareness regarding the guarantees of The Patient's Charter.

We also note that their interpretation of the term 'initial assessment' is at variance with that expressed by the NHS Chief Executive in a widely circulated document.¹

METHODS AND RESULTS

We conducted an interview-based survey of all patients attending the A&E Department of St Bartholomew's Hospital from 17 to 24 August 1992. This is an inner-city department serving a mixed commuter and residential population and 40 000 new patients present per year.

A pilot study was performed in which patients were asked to complete a questionnaire handed to them by the reception clerk. A very poor completion rate (10%) and misinterpretation of several questions led us to adopt an interview-based approach. Medical staff and volunteer medical students mounted a 24-h rota in an attempt to intercept every patient attending the department in the 7-day period. They asked standardized questions from a pre-printed questionnaire (patients not interviewed were sent a postal questionnaire).

A total of 584 patients were registered during the course of the study, of whom 404 were interviewed on their initial attendance (69%). A further 47 responded to the postal questionnaire, giving a total of 451 data sets. The interviewers recorded 51 cases in which they were unable to conduct the interview because of communication difficulties, lack of cooperation or severity of illness. The completion rate among the 533 patients who were in a position to complete the questionnaire was 85%.

There were variable rates of response for each of

Question	No. of patients	Response rate (%)
1. Were you aware of your guarantee of immediate assessment on arrival in the A&E department?	51	94
(a) Yes	372	
(b) No	39	90
2. What period of time do you think is appropriate for 'immediately'?	(a) Within 1 min	
(b) Within 5 min	93	
(c) Within 15 min	179	
(d) Within 1 h	87	
(e) Longer	7	91
3. Who do you think should perform your initial assessment?	(a) Doctor	
(b) Nurse	155	
(c) Receptionist	221	
(d) Other	32	
	3	

Table 1. Facsimile of the questionnaire