Treatment of scalp wounds in head injured patients requiring transfer to a neurosurgical unit

EDITOR,—Scalp wounds are a common reason for attendance in the accident and emergency (A&E) department. Some of these cases will have an associated head injury and require transfer to a neurosurgical unit. We examined the treatment of scalp wounds in this group. In a six month period, 142 patients were admitted to the neurosurgical unit with the diagnosis of head injury. Thirty six of these patients had associated scalp wounds and details of this group are presented.

Twelve patients had adequate treatment of the scalp wounds in the A&E department. In all of these patients the hair around the wound had been removed, the wound cleaned, and the skin closed. Of the remainder, 14 patients had received no treatment of their wounds despite the presence of the wound being clearly documented in the notes. In 10 patients there had been attempts to treat the wounds that were inadequate because of incomplete cleaning (three cases) or poor closure (seven cases). These 24 patients all required further exposure, cleaning, and suturing of their wounds by the neurosurgical staff. Additional wounds that had not been found before transfer were identified in five cases. In one patient the failure to deal adequately with a scalp wound resulted in a marked blood loss which required resuscitation and blood transfusion.

This study indicates that the treatment of scalp wounds in severely head injured patients is often inadequate. The reasons underlying this are not clear. Perhaps there is a feeling that, if the patient is being transferred for neurosurgical assessment, scalp wounds should be left untreated. We suggest that this is not a good standard of care. Furthermore, clinicians involved in the care of trauma victims should not be reluctant to adequately expose scalp wounds. This is the key to proper treatment.

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UK accident and emergency departments and emergency contraception

EDITOR,—I read the article on the provision of emergency contraception in the accident and emergency (A&E) department by Gbolade *et al* with interest.¹ Of course this “emergency contraception” is a misnomer in that it is neither an emergency, as there is a 72 hour time window, nor is it a contraceptive as it acts by stopping implantation of the “conception”.

Most departments are trying to target their resources to A&E patients. By doing this in Lancaster we have, with the help of the health authority and local general practitioners, kept our new patient numbers static at around 35 000 a year over the past 10 years. Extra resources have then helped to keep our waiting times down to an average of 30 minutes. The converse of this is that any A&E department that attempts to be all things to all people will quickly be overwhelmed by the demand of the public for general health care.

The questionnaire was sent to the person in charge of each A&E unit (of whom one in three did not respond), yet as the survey demonstrated the consultants were rarely involved in prescribing the initial dose. Perhaps a questionnaire sent to all permanent staff grades in A&E might better reflect the views of the doctors who would be expected to provide the prescription and advise the women.

The issue of deregulation and having the service available “over the counter” at a chemist is a separate issue, although this in itself would have staff issues of training and reluctance on personal, religious, and moral grounds.

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- 1 Gbolade BA, Elstein M, Yates D. UK accident and emergency departments and emergency contraception: what do they think and do? *J Accid Emerg Med* 1999;16:35–8.

The authors reply

We appreciate Dr McGlone's interest in our paper but his letter shows some misunderstanding of our study. We disagree with his assertion that the phrase “emergency contraception” is a misnomer. The noun “emergency” means an unexpected occurrence, requiring immediate action; “contraception”, also a noun, means the prevention of unwanted pregnancy. For a couple facing the risk of an unplanned and unwanted pregnancy, especially after failure of a barrier method of contraception, it is definitely an emergency situation.

The findings of the survey suggested that the willingness to provide the service appeared to be dependent on a multiplicity of interacting factors including the ethos and leadership of the department. Sending the questionnaire to all permanent staff would not have been useful in that if the leadership was not receptive to the idea in the first place, little could be achieved by the supporting staff.

In noting the opposition to “over the counter” availability of emergency contraception, we were highlighting the incongruity between the apparent reluctance of the accident and emergency departments to provide the service and their reluctance to support measures that would remove the pressure being brought on them to provide the service.

Importance of histology

EDITOR,—A 47 year old male recently presented to this accident and emergency (A&E) department complaining of a painful lesion on his right forearm. He related this to a pointed wire penetrating his skin three weeks previously. Examination revealed an apparent collection of pus on the right forearm with surrounding induration and redness. Radiography demonstrated no foreign body. This lesion was incised and drained, an appropriate dressing applied, and oral antibiotics prescribed. The patient was discharged.

Seven weeks later the patient experienced a recurrence of pain in his right forearm. Examination again showed an apparently small collection of pus. Incision and drainage revealed an odourless “pearl white material”. Histopathological examination returned a diagnosis of pilomatrixoma with “nuclear atypia and focal necrosis”.

Figure 1 High power view showing basaloid cells in lower part of the field undergoing pilar-type keratinisation, forming a mass of keratinous “ghost” cells. The masses of keratin could be mistaken for a foreign body (magnification $\times 52$).

A pilomatrixoma is a nodular benign tumour arising from the hair matrix. The differential diagnosis includes basal cell carcinoma, keratoacanthoma, and metastasis. It is most often seen in children and young adults, and most cases are located on the head, neck, and upper extremities. Typical features include nests of small basaloid cells, which undergo abrupt keratinisation to form “ghost” and “shadow” cells (fig 1). Extramedullary haematopoiesis, foreign body reaction, calcification, and ossification are seen. An association between pilomatrixoma and trauma has been suggested previously.¹ Malignant forms of pilomatrixoma are described.² These exhibit cellular atypia, an infiltrating border, mitoses, necrosis, clear cells, and transitions to squamous cells. Local recurrence is seen after inadequate excision. Metastases to distant sites are described.³

In view of the atypical features in this case, this man was referred to the dermatology service where he underwent wide local excision of this lesion.

This case demonstrates the importance of obtaining histological examination of all tissue samples when patients undergo minor surgical procedures in an A&E department. Making a clinical diagnosis without such objective evidence may miss potentially serious conditions, including malignant skin lesions.

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- 1 Inui S, Kanda R, Hata S. Pilomatrixoma with a bullous appearance. *J Dermatol* 1997;24:57–9.
- 2 McCulloch TA, Singh S, Cotton DW. Pilomatrix carcinoma and multiple pilomatrixomas. *Br J Dermatol* 1996;134:368–71.
- 3 Niedermeyer HP, Peris K, Hofler H. Pilomatrix carcinoma with multiple visceral metastases. Report of a case. *Cancer* 1996;77:1311–4.

Overdose on the internet

EDITOR,—A 27 year old man attended our accident and emergency department having taken between 60 and 85, 60 mg tablets of phenobarbitone and half a bottle of vodka. He complained of dizziness and was noted to be drowsy and have slurred speech. The tablets had been ordered via the internet from a company based in Thailand and were purchased for the sum of \$21. This was not a suicide attempt but was, he said, an experiment to help him relax. On further questioning he also admitted to taking a wide variety of vitamins and mineral supplements bought from the same company. The patient had a serum phenobarbitone concentration of 71.5 mg/l

(normal therapeutic range 15–40 mg/l, serious toxicity 100 mg/l).¹ He was treated with multiple oral doses of activated charcoal. His signs and symptoms settled after 72 hours and he was discharged.

Doctors should be aware that access to a wide variety of "prescription only" drugs is now easy and unrestricted. If this continues we can expect to see many more overdoses, both intentional and accidental, involving unusual drugs and in a population not previously associated with drug overdose.

Furthermore, the internet has now broken down the protective role of both the pharmacist and the doctor in controlling access to prescription only medication. We propose that access to internet sites marketing prescription only drugs be limited in the same way that internet service providers block access to pornographic sites.

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- 1 Doyon S. Anticonvulsants. In: Goldfrank JR, Flomenbaum NE, Lewin NA, *et al.*, eds. *Goldfrank's toxicological emergencies*. 6th Ed. Connecticut: Appleton and Lange, 1998: 689–98.

Excessive morphine requirements after pre-hospital nalbuphine analgesia

EDITOR,—We read with interest the paper by Houlihan *et al* in which they presented 10 cases where patients required excessive morphine to control their painful symptoms after the administration of pre-hospital nalbuphine analgesia.¹

We agree with the statements made in the paper regarding the pharmacokinetics and dynamics of nalbuphine in relation to its effects on the μ and κ receptor subtypes. Theoretically it is logical that this agent would have implications on subsequent dosing using μ agonist opioid analgesics, and anecdotally colleagues have reported difficulties in controlling painful symptoms in patients who have received parenteral nalbuphine administered in the pre-hospital setting.

With this in mind two years ago we undertook a pilot study of 50 patients who had received parenteral nalbuphine analgesia in the pre-hospital setting. Following a list of inclusion and exclusion criteria patients were recruited and assessed on arrival in the accident and emergency (A&E) department

and asked to report a verbal pain score. If they required further analgesia the patients received equipotent doses of either morphine or diamorphine. Subsequent pain scoring was done at 30 minutes and any further analgesia required was documented.

A control group of 50 patients was recruited of similar age and case mix who had not received parenteral nalbuphine. The results when analysed were tested using the Mann-Whitney U test. There was no significant difference between the pain scores on arrival in the department between the control and nalbuphine group and furthermore the decline in pain scores after the adjuvant morphine or diamorphine in the department was significantly greater in the group who had not received nalbuphine.

Accepting that this study at the time was largely observational and that flaws existed in the methodology we did, however, feel there was a question that warranted putting under the scrutiny of a randomised controlled trial. The drug tramadol, a weak pure μ agonist analgesic (which also has analgesic properties mediated via serotonergic and noradrenergic pathways in the central nervous system) seemed a logical drug with which to compare nalbuphine. The side effect profiles of the two drugs are similar and like nalbuphine tramadol does not have a controlled drug status. We set up and obtained ethical approval to carry out a double blind randomised controlled study looking at the analgesic properties of the two drugs when administered in the pre-hospital setting and aimed to compare the ease with which painful symptoms could be controlled subsequently in the A&E department.

After obtaining ethical approval and organising the blinding and randomisation aspects of the study we have faced significant barriers in attempting to implement the study in the pre-hospital setting. Despite correspondence with the local Paramedic Steering Committee, the Joint Colleges Ambulance Liaison Committee and the head of Wiltshire Ambulance Service, we have yet been unable to take this trial any further forward as the ambulance service feel unable to administer tramadol as it is a drug that is not included on their list of agents which they are legally allowed to administer.

We would be grateful to hear from any physicians who have faced similar problems in setting up pre-hospital randomised controlled trials involving new drugs. We would be indebted to anyone who could furnish us with the name and address for correspondence of the individual or body who could facilitate this aspect of the trial such that it could start as soon as possible. Having read the paper by

Houlihan *et al* it is clear that we are not the only two clinicians who feel that this issue should be drawn to a scientific conclusion.

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- 1 Houlihan KPG, Mitchell RG, Flapan AD, *et al.* Excessive morphine requirements after pre-hospital nalbuphine analgesia. *J Accid Emerg Med* 1999;16:29–31.

NOTICE

Teaching the Teachers to Teach

18–19 November 1999, Offley Place, Herts

This is an opportunity to to improve teaching and presentation skills and understand basic educational theory in a supportive setting.

Further details: Miss Cilla Reid, Accident and Emergency Department, Lister Hospital, Coreys Mill Lane, Stevenage, Herts SG1 4AB (tel: 01438 314333 bleep 1048, fax: 01438 781234) or Jan Caspell, coordinator (tel: 01438 781175, direct line).

Correction

We regret that an error occurred in the emergency casebook by M J Clancy published in July (Persistent "haematoma". *J Accid Emerg Med* 1999;16:303). Mr Clancy's two coauthors were inadvertently omitted from the published version. The authors should have read: M J Clancy (Emergency Department), M Sampson (Department of Radiology), S Lambert (Department of Trauma and Orthopaedics), all at Southampton General Hospital.