missed by a routine clinical examination. It would be interesting for these data to be subjected to peer review so that they may be more thoroughly evaluated by a wider audience.

- 1 Turner M, Esaw M, Clark RJ. Carbon monoxide poisoning treated with hyperbaric oxygen: metabolic acidosis as an indicator of treatment requirements. *J Accid Emerg Med* 1999;16:96–8.
- 2 Turner M, Hamilton-Farrell MR, Clark RJ. Carbon monoxide poisoning: an update. *J Accid Emerg Med* 1999;16:92–6.

Pre-hospital nalbuphine analgesia

EDITOR,—I read with interest the paper by Houlihan *et al.*¹ I thus ask the question why they did not continue to use nalbuphine as the analgesic in their accident and emergency unit? It is a drug that has been around since 1963 with only about 80 or 90 adverse reactions and no deaths ever related to this analgesic. Its dosage has been described as up to 200 mg without adverse effects. One would have thought that in cases 1 and 2, if their patients required further analgesia, they could have continued with a 20 mg or 40 mg dose as needed to control the pain, without resorting to opiates.

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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.

The authors reply

We read with interest Dr Jones' comments on our article. We agree that nalbuphine is a potent analgesic agent with few adverse effects and no reported fatalities. Nalbuphine has gained wide acceptance in a variety of clinical situations including the field of pre-hospital care. We acknowledge that it is possible to persevere with nalbuphine when additional analgesia is required after arrival in hospital, but it is our experience that the treatment of moderate to severe pain more commonly includes the administration of intravenous morphine and related opioids which are titrated to gain rapid and effective pain relief. This policy is adopted by the majority of clinicians involved in treating acute medical and surgical emergencies in our area. The prime objective of our article was to report excessive morphine requirements in certain patients who had received nalbuphine before arrival at hospital. This phenomenon has been previously discussed but only as a theoretical occurrence and had not been reported in practice. We contend that our experience merits discussion and additional evaluation of policies of analgesia administration.

Securing intercostal drains

EDITOR,—The method of securing chest drains described by Boyle using a 1cm cylinder of portacath tubing provides a simple technique for adjusting the position of an intrapleural drain.¹ However, the commonest reason for a chest drain "falling out" is that an inadequate bite of tissue is taken with an anchoring suture of inadequate tensile strength. It is not commonly due to poor knot tying by inexperienced clinicians. As a further simplification of the method described, if the

chest drain is moved to one end of the chest wall wound, a single suture (for example a No 1 Ethilon suture on a curved hand held needle) secured as described by Boyle would hold the drain in situ perfectly adequately. If this single anchoring suture were tied flush thus approximating the skin against the intercostal tubing, then any potential air leak at skin level (should it prove necessary to apply high flow low pressure suction) would be obliterated. The remainder of the chest wound can then be closed with simple interrupted sutures of the clinician's choice.

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- 1 Boyle A. Securing intercostal drains. *J Accid Emerg Med* 1999;16:239.

Ectopic pregnancy

EDITOR,—The diagnosis of ectopic pregnancy continues to present a challenge to the emergency physician as reliance on the standard history and examination is insufficiently sensitive. Early diagnosis and referral limit the morbidity and mortality associated with this potentially life threatening condition, which accounts for 8% of all maternal deaths.¹ Previous studies have shown that only 33%–53% of cases are diagnosed correctly on initial presentation.^{2,3} Clancy and Illingworth have suggested that incorrect diagnoses were made either because ectopic pregnancy was not considered or because relevant symptoms and signs were overlooked.³

Dart *et al* identified findings in both the history and physical examination that were predictive.⁴ Pain that was moderate to severe, lateral in location, and/or sharp in nature was important. The presence of an intrauterine contraceptive device within the previous year, a history of infertility, pelvic surgery, or tubal ligation were also noted to be predictive for ectopic pregnancy. The presence of cervical excitation, lateral or bilateral abdominal tenderness, lateral or bilateral pelvic tenderness, and positive peritoneal signs were important in the examination. However no constellation of findings resulted in a highly reliable diagnostic tool. The most important of these signs were the history of tubal ligation (odds ratio 18.0) and the presence of positive peritoneal signs (odds ratio 7.9).

We performed a retrospective case note review of all patients attending the West Middlesex University Hospital accident and emergency department between January 1994 and June 1998 (55 months) in whom an ectopic pregnancy was subsequently confirmed. We looked in detail at those in whom there was a delay before diagnosis using an evaluation questionnaire to assess the clinical findings.

Of 109 patients, 70 (64%) cases of ectopic pregnancy were correctly diagnosed at first presentation. In the remaining 39 cases (36%) the most common historical features leading to a diagnostic delay were the absence of pain or the poor localisation of that pain. The most common atypical findings were the absence of cervical excitation and adnexal tenderness. The most common initial misdiagnosis was miscarriage.

The diagnosis of ectopic pregnancy continues to be difficult, mainly because the symptoms and signs often do not fit a recognised pattern. In particular the presence of abdominal pain is considered to be impor-

tant in the diagnosis of ectopic pregnancy, as is adnexal pain and cervical excitation. Doctors may not consider the diagnosis of ectopic pregnancy when any one of these features is absent. The diagnosis must always be considered in pregnant patients who have yet to have an intrauterine pregnancy confirmed on ultrasound scan. It is essential that the presence, location, and nature of pain is fully elucidated. In addition, a history of tubal surgery should always be sought.

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- 1 Department of Health and Social Security. Report on confidential enquiries into maternal deaths in the United Kingdom 1988–90. London: HMSO, 1994;6:66–7.
- 2 Gilling-Smith C, Panay N, Wadsworth J, *et al.* Management of women presenting to the accident and emergency department with lower abdominal pain. *Ann R Coll Surg Engl* 1995;77:193–7.
- 3 Clancy M J, Illingworth RN. The diagnosis of ectopic pregnancy in an accident and emergency department. *Arch Emerg Med* 1989;6:205–10.
- 4 Dart RG, Kaplan B, Varaklis K. Predictive value of history and physical examination in patients with suspected ectopic pregnancy. *Ann Emerg Med* 1999;33:283–90.

Foreign body in the throat

EDITOR,—A 1 year old baby girl was brought to the accident and emergency (A&E) department of Bishop Auckland General Hospital with a history of "swallowing" a ring that she and her 4 year old sister had been playing with. She had difficulty in breathing with choking, coughing, and blueness of the face.

She arrived in the A&E department in a distressed condition with the mother holding her head down as this eased her breathing. Portable radiography of the chest and neck revealed a radio-opaque foreign body (ring) lodged in the upper respiratory tract (fig 1). Back slapping and attempted finger sweep of the mouth and throat was unsuccessful. The child was kept in the head down position until a general anaesthetic could be administered and the ring retrieved from her pharynx.

Figure 1 Radiograph showing ring in the child's throat.

The lumen of the ring prevented total airways obstruction and saved this child's life.

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Is this a record? Six years in "Paris"

EDITOR.—We should like to bring to your attention an interesting patient who presented recently at our accident and emergency (A&E) department.

The patient was a homeless man, aged 64, who lived rough and was well known in the area. In November 1992 he fell and injured his left knee while under the influence of alcohol. Radiography of his knee showed a simple fracture of the patella. He was put into a plaster of Paris cylinder for four weeks, to be reviewed at the end of that period.

Four weeks later he was seen in the fracture clinic for assessment. The plaster was removed on arrival. He had a stiff knee but with no tenderness over the patella at all. He was to be put into a Tubigrip support bandage and to be reviewed two weeks later. However, he was actually put into a Dynacast plaster and told to come back in two weeks for review; he failed to keep his appointment.

Almost six years later, in October 1998, the patient arrived in the A&E department, with a request from his general practitioner (GP), to have his plaster removed.

The Dynacast plaster was filthy, foul smelling, but undamaged and it was with some sense of trepidation that the plaster was removed with an electric saw. The limb was covered in dead squamous tissue and had four small areas of superficial ulceration. He was able to straight leg raise and to demonstrate about 15 degrees of flexion on removal of the cast. The leg was cleaned and, other than some generalised pallor and thinning of the skin, was found to be extremely healthy. He had very little movement of the knee joint but good ankle and hip joint movements. His leg was dressed with mupirocin and a paraffin gauze dressing and then a conforming bandage.

During his six years of wearing his Dynacast cylinder he had walked to Cornwall and to the Midlands, some considerable distances from his home town. In doing so he had lived rough for the majority of that time. In order to move freely he had developed a Parkinsonian type shuffle, which was most effective.

The Dynacast was in excellent condition, as was the stockinette. The wool and other protective dressings, however, were showing sign of degradation. Neither Smith and Nephew, makers of Dynacast, nor ourselves have been able to find any reference to any form of prolonged treatment with a plaster of this nature reported in any of the medical or nursing literature.

There are lessons to be learned from this case. The principal one is the importance of ensuring that when plans in management are altered that records must be altered as well. In this case the patient was seen, or to be seen, by two doctors. As there was no written alteration to the plan on the first attendance at the fracture clinic the second doctor was not to know that the patient was not in a Tubigrip bandage when last seen. It is understood that, because of the nature of his life style, a verbal change of plan was given and a further two weeks in a cylinder was recommended.

Interestingly, the patient decided to remove the plaster as he had chosen to retire from the road as he now felt that there were too many unpleasant people travelling on the roads.

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BOOK REVIEWS

The Midnight Meal and Other Essays About Doctors, Patients, and Medicine. By Jerome Lowenstein. (Pp 128; £12.50.) Yale University Press, 1997. ISBN 0-300-06816-6.

The Midnight Meal. The very words brought back vivid memories of comforting cheese omelettes, or bacon and beans, eaten with relish in the middle of nights "on take", waiting for the bleep to go off again. Memories of real food at night, before packaged meals and microwaves on hospital corridors.

In this collection of essays, Dr Jerome Lowenstein, a professor of medicine at New York University Medical Center and a long-time member of the staff of the Bellevue Hospital, writes about some of the changes he has seen in the way medicine is practised, and he reflects on some traditional values, which at times appear to be in danger of extinction.

Many of his essays, such as "Can you teach compassion?" are about a "humanistic" approach to medicine, which he has tried to nurture in his junior staff. He recalls an intern presenting a patient as a, "Thirty five year old IVDA . . .", and asking, "Would our thinking or care be different if you began your history by telling us that this is a 35 year old marine veteran who has been addicted to drugs since he served, with valor, in Vietnam?". Such attention to patients as individuals is a strong theme throughout. Patients, in Dr Lowenstein's hands, are not examples of interesting conditions, they are distinct personalities with their own special fears and emotions. "Every patient has a name and a story, yet many seem to remain almost as nameless as patients brought in comatose to the emergency room as 'unknown white female'", he writes, as he ponders the dilemma between listening to patients, and the pressure to get each one treated quickly and effectively.

Several of his essays concern the patient-physician relationship. "On drawing blood" examines the importance of this simple task in allowing medical students to begin making physical and psychological contact with patients. In "Asymmetry" he discovers, from talking with colleagues, that although in a particular patient-physician relationship there is an asymmetry in the amount of uncertainty, fear, pain, or helplessness felt by the two parties, the physician has to cope with the cumulative effect of repeated "asymmetries".

Dr Lowenstein takes a look at some of the changes in medicine and medical practice,

such as "The biomolecular revolution", and our increasing reliance on numbers: measuring concentrations and defining treatment thresholds. In "The whole truth . . ." he acknowledges progress made in favour of patient autonomy. He does not suggest that we turn back the clocks: the pace of medicine has changed too much for that, but he does lament the passing of institutions, like the midnight meal, which fulfilled far more than just feeding busy clinicians.

In "Shaky evidence" he takes a playful swipe at evidence based medicine, meta-analyses, and outcomes research, and questions some of their underlying principles. As with the rest of this collection Dr Lowenstein manages to engage the reader with his insights and the deftness of his touch.

This book is not only a good read: it is stimulating and uplifting. It reminded me of my house jobs, the physicians who taught me, and my motives for going into emergency medicine.

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Oxford Handbook of Accident & Emergency Medicine. By J P Wyatt, R N Illingworth, M J Clancy, P Munro, C E Robertson. (Pp 782; £18.95.) Oxford Medical Publications, 1999. ISBN 0-19-262751-1.

Never judge a book by its cover, the saying goes. This book certainly lives up to its outward appearance—the cover is purple and yellow. Historically, both colours are significant—the former adorning Roman Emperors and the latter being revered by the Sun King, King Louis XIV and hence the yellow room in the Palace of Versailles.

I admire the authors for taking on the responsibility to produce such authoritative guidance on such an exhaustive subject. The book is comprehensive yet concise. It is easy to read yet may also be used as a reference book. Many accident and emergency (A&E) senior house officers who use the book as guidance find it extremely useful. It contains facts pertinent and particular to A&E which may only be found in other books either with difficulty or not at all.

The book is also a great time saver in that it contains the latest guidelines and protocols such as the British Thoracic Society guidelines for asthma, and they are all in one easy to find place. It is logical, practical, and well structured.

Where there is pictorial representation, it is done extremely well. This is particularly true in the nerve block chapter (analgesia and anaesthesia).

If I were to suggest any improvements, it would be to highlight in red or italics the critical points—for example, contraindications and pitfalls. It would also be nice to have a small section on a career in A&E medicine.

This is an invaluable adjunct for present A&E senior house officers. The ultimate compliment is to say I wish I had had this as a senior house officer as it would certainly have reduced my stress levels, in addition to augmenting my medical knowledge.

This book will be of benefit to junior doctors, medical students, nurses, and paramedics as well as general practitioners.

I hope we are at the stage when junior doctors can once again begin to say that they have