management prior to transfer was a Glasgow Coma Score of less than 8, as in such unconscious patients airway obstruction may be insidious and unrecognized. In addition, there was a requirement for a guaranteed supply of 100% oxygen (Meredith & Vale, 1988) and a necessity to lower suspected elevation of intracranial pressure by hyperventilation. These needs would have been met by intubation and ventilation.

We perform approximately 300 critical care transfers per annum, both by rotary and fixed wing aircraft. We endotracheally intubate 80% of patients to ensure optimum oxygenation and ventilation and would not contemplate transferring an unconscious CO poisoned patient without first protecting the airway in this fashion. Until appropriate patients are accorded this most fundamental intervention, there will continue to be avoidable morbidity and mortality in inter-hospital transfers.

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Computer-assisted diagnosis and abdominal pain

Sir

P. A. Stonedbridge *et al.* (1992) in their article on computer-assisted diagnosis (CAD) and abdominal pain have concluded that a gradual fall in the diagnostic accuracy of CAD is probably due to so-called 'routine use factor', doctors losing initial novelty value of computer usage and enthusiasm. This experience is somewhat predictable. However, it is a pity that over-emphasis on CAD, especially in the accident and emergency (A&E) setting, somehow under-valued the use of traditional, human, clinical skill. A previous study (Lawrence *et al.*, 1987) has shown that the use of a structured data sheet alone was as useful as CAD in diagnosing correctly the acute abdominal pain. The author and his colleagues (Maitra *et al.*, 1988) demonstrated that relatively experienced doctors using standard,

clinical skill can match CAD accuracy rates stressing the importance of continuing clinical teaching and supervision of junior doctors. CAD does provide an ongoing database which would help medical audit as has been rightly stressed. However, the general advocacy of use of CAD for diagnostic purposes in the busy A&E department would not only be time consuming, leading to increased patient waiting time, an important factor determining patient satisfaction, (Maitra & Chickhani, 1992) but would also not be cost effective (not improving patient care because the diagnostic accuracy rate is low).

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Foley catheter haemostasis for penetrating cardiac wounds: the need for caution

Sir

We were interested to read the article on intracardiac fluid therapy following emergency thoracotomy (Moulton *et al.*, 1992) in your June issue. We would like to comment on the use of Foley catheter (balloon) haemostasis for penetrating cardiac injuries.

Recently we used this technique of balloon haemostasis and fluid administration in a young male patient who was brought in with a stab wound to his left anterior chest wall. He presented with signs of hypovolaemia and cardiac tamponade. He underwent an emergency thoracotomy which revealed a haemopericardium and an anterior left ventricular penetrating wound. Following pericardial decompression, a Foley catheter was introduced through the ventricular wound and the balloon inflated to 10 ml. This only achieved partial haemostasis as the bleeding continued from the wound margin. Traction on the balloon led to an increase in the wound size. Inflation of the balloon to 20 ml caused a significant drop in his already reduced systolic blood pressure. We were able to administer a large volume of crystalloid solution and blood through the Foley catheter very rapidly and this helped his perfusion. Our patient however continued to bleed and died.