

ATLS courses

Sir

I completed an Advanced Trauma and Life Support (ATLS) course in March this year. The next day I was senior house officer (SHO) on call covering general surgery for the weekend when a call was put out for the trauma team to report to the resuscitation room in the accident and emergency (A&E) department.

A helicopter had crashed and a survivor was in the resuscitation room. Following immediate intubation examination revealed that he had a superficial wound to the left upper chest and a flail segment of that same side with poor air entry. I inserted a large chest drain immediately, without radiological confirmation, and the aspiration of air and blood improved his oxygenation.

Following rapid infusion of fluid and blood as per ATLS guidelines his blood pressure rose to 110/90 mmHg and his heart rate was 120 beats min⁻¹. He had a fracture of the left femur and radiographs of the cervical spine, chest and pelvis revealed a fracture of the pelvis and marked shadowing in the left lung field with multiple rib fractures.

The case demonstrated clearly to me the value of the ATLS course I had just attended. In a crisis situation it gives a system of working whereby a patient can be managed quickly and in an orderly fashion. I would encourage everyone who deals with trauma to undertake this valuable course.

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Emergency eye care in the accident and emergency department

Sir

I read with interest the article on 'Eye irrigating lenses' (Fernandes, 1991). We have developed a polymethylmethacrylate scleral lens similar to the Morgan lens but with the modification that considerable flow is directed to the upper and lower fornices where particulate and concentrated liquid often collects. It is important to make the delivery of emergency eye care in an accident and emergency (A&E) department as effective and easy as possible. A&E departments may be keen to use either the Morgan lens or the Moorfields lens as these lenses allow easy and efficient large volume irrigation in a controlled manner. However, it is imperative that they should be aware of the limitations and specific method of use in certain circumstances.

Chemical injuries to the eyes are particularly dangerous when caused by alkaline materials such as lime and ammonia. It is common for alkaline particulate matter to embed itself in the fornices and in the subtarsal region. There is a very real risk of these particles continuing to damage the eye after irrigation has removed free

alkali and we always double evert the upper lid and remove all particulate matter with a forceps. Secondly, we recommended that the pH of the conjunctiva should be tested before and after irrigation with these lenses. In our experience more than a litre of saline or Ringer's lactate is frequently required with alkali burns before the pH returns to normal and occasionally several litres are required.

The use of these irrigating lenses in A&E departments should be encouraged and I congratulate Dr Fernandes for bringing these lenses to our attention.

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REFERENCE

Fernandes C. M. B. (1991) Eye irrigating lenses. *Archives of Emergency Medicine* 8, 274–276.

Waiting times and patient satisfaction in the accident and emergency department

Sir

We read with interest the paper by Booth *et al.* (1992). We have carried out two studies on patient satisfaction using short, structured questionnaires at 2-yearly intervals. The data of the first study will be published shortly. We thought it would be of interest to your readers to know the findings of our study.

We obtained data from patients during a 7-day period, but this was spread over 2-weeks to include each day of the week to minimize variation. The response rate was just over 50% out of 850 attenders. The main conclusion arrived at was that the patients satisfaction was correlated directly not only with the waiting time to see the doctor ($P = 0.003$) and total waiting time ($P = 0.01$), but also with the doctors explanation about management ($P = 0.02$). Of patients, 27.8% noted that they did not receive any explanation from the nurse about what was going to happen and 61.1% received no information about possible delay, although these factors had no positive correlation with patient satisfaction.

The last two findings came as a surprise to the staff which was probably due to: lack of staff awareness of the importance of imparting information; lack of training in information provision; and lack of established procedure for giving information to the patient.

The second study was conducted after the information provision was improved but the patient satisfaction rate remained fairly static i.e. changing only from 95 to 93.5%. This may however be explained by the fact that still only 85% of patients are seen within an hour of registration by the doctor. Any further improvements to satisfy the Patients Charter are unlikely to be attainable within the present financial constraints.