

## Letters to the Editor

### Plaster checks

I write in response to the review of plaster checks by G. Riding, M. Edgell and M. James.<sup>1</sup> Stated another way, 76% of their plasters were not altered and 16% of patients described the return visit as 'inconvenient'.

A recent editorial noted successes with telephone follow-up consultations subject to certain safeguards.<sup>2</sup> Perhaps the authors could run their plaster checks along these lines for a trial period.

Suitable patients treated with a plaster are given written advice on care of the cast and occasions on which they should return to the department. The next planned follow-up in the department is for removal of plaster. Unless the patient re-presents personally with problems, the 'plaster check' takes place over the telephone. The clinic doctor should have appointed times for telephoning and have access to radiographs and notes. A few simple questions can confirm that the patient is comfortable and safe in the cast. Advice can be reinforced and a return to the department negotiated if there is concern.

The process is unlikely to save much in resource terms. It would however, eliminate travelling and waiting for recently injured patients who are unable to drive.

### REFERENCES

1. Riding G., Edgell M., James M. (1994) Plaster checks; a waste of resources? *Journal of Accident and Emergency Medicine* **11**, 266–267.
2. Rao J.N. (1994) Editorial – Follow-up by telephone. *British Medical Journal* **309**, 1527–1528.

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### Head injuries and the observation ward

Brown and co-authors point out the considerable influence that the availability of a short-stay observation ward can have on the admission rates of patients with head injuries.<sup>1</sup> In describing this somewhat predictable discovery, however, the authors have greatly understated the contribution that an

observation ward can make to the safe and rewarding management of the head injured patient in an accident and emergency (A&E) department and beyond.

The Royal Liverpool University Hospital (RLUH) has a large and fairly typical city centre A&E department with approximately 85 000 new patients attending every year. The department is fortunate in possessing an integral 18-bedded short-stay observation ward, which has become a vital part of dynamic emergency care in the hospital. In the first 6 months of 1994 when there were 42 087 new attendances at the A&E department, 1833 patients were admitted to this ward (representing 4.36% of the total number of A&E department patients). Of the patients admitted to the ward, 393 (21%) had sustained a head injury and, of these, 332 (84%) were discharged home following uneventful observation over an average period of 12.15 h. A further 33 patients (8%) took their own discharge against medical advice and were lost to follow-up. Twenty-six patients (7%) required admission to other wards within the RLUH or transfer to another hospital. The majority of these referrals (23 patients) were for orthopaedic or maxillofacial problems. Only three patients (0.7% of all head injuries) required neurosurgical transfer for the management of complications of their original injuries.

These figures again underline the obvious: that the overwhelming majority of head injured patients admitted for observation are subsequently discharged following uneventful recovery. The implication of Brown *et al.*<sup>1</sup> is that, strictly speaking, the admission of head injured patients to an observation ward is an unnecessary luxury. What they completely ignore, in our opinion, is firstly that many patients who are head injured are intoxicated or confused or both, and an integral A&E department observation ward can provide an invaluable option for procrastination for hard pressed clinical staff confronted by such patients. The oft described stress associated with emergency medicine is greatly tempered when a ward where clinical issues can crystallize or dematerialize with time is readily available. Second, an integral observation ward not only allows the identification of acute complications close to resuscitation facilities and staff but it also offers the potential for reducing the considerable neuropsychiatric morbidity attending many head injuries. Economic and neuroscientific constraints have historically directed the