

- patients with mild head trauma. *Ann Emerg Med* 1993;22:1148-55.
- 22 Reinus W, Erickson K, Wippold F. Unenhanced emergency cranial CT: optimising patient selection with univariate and multivariate analyses. *Radiology* 1993;186:763-8.
- 23 Schynoll W, Overton D, Krane R, *et al.* A prospective study to identify high yield criteria associated with acute intracranial CT findings in head-injured patients. *Am J Emerg Med* 1993;11:321-6.
- 24 Ditrich A, Bowman M, Ginn-Pease M, *et al.* Pediatric head injuries: can clinical factors reliably predict an abnormality on CT? *Ann Emerg Med* 1993;22:1535-40.
- 25 Shackford S, Wald S, Ross S, *et al.* (1992) The clinical utility of computed tomographic scanning and neurologic examination in the management of patients with minor head injuries. *J Trauma* 1992;33:385-94.
- 26 Jeret J. *J Trauma* 1993;35:490 [correspondence].
- 27 Stein S. *J Trauma* 1993;35:491 [correspondence].
- 28 Jeret J, Mandell M, Avitable J. "Mild" head trauma: a deceptive term [abstr]. *Neurology* 1993;43:A218.
- 29 Stein S, Ross S. Mild head injury: a plea for routine early CT scanning. *J Trauma* 1992;33:11-13.
- 30 Macpherson P, Jennett B, Anderson E. CT scanning and surgical treatment of 1551 head injured patients admitted to a regional neurosurgical unit. *Clin Radiol* 1990;42:85-7.
- 31 Livingston D, Loder P, Hunt C. Minimal head injury is admission necessary? *Am Surg* 1991;57:14-17.

ADVANCED LIFE SUPPORT GROUP

Major Incident Medical Management and Support Courses: to be held in various centres throughout the UK in 1996. This is a three day course in "life support style" designed to train health service personnel to provide an effective response at a major incident.

Fee £300.00

Advanced Paediatric Life Support Courses: to be held in various centres throughout the UK in 1996. This is a three day course designed to provide training which will enable doctors and nurses to deal efficiently with all paediatric emergencies. The course is modular and has sections on paediatric resuscitation, serious illness and serious injury.

Fee varies according to centre. Range £300.00 – £350.00.

Inquiries for both courses to:
 Jenny Antrobus
 Advanced Life Support Group
 A&E Dept
 Hope Hospital
 Stott Lane
 Salford M6 8HD
 Tel 0161 787 4345

OUTCOME	
If referred, RMO's assessment:	
Admitted	<input type="checkbox"/>
Discharged by RMO / Chest Physicians	<input type="checkbox"/>
Discharged by A&E staff	<input type="checkbox"/>
DISCHARGE PLAN	
FOLLOW UP	
- GP review (within 5 days) plus letter	
- Consider Chest clinic referral	<input type="checkbox"/>
Inhaler technique checked	<input type="checkbox"/>
Asthma information leaflet offered	<input type="checkbox"/>
Medication	<input type="checkbox"/>
- Start inhaled steroids: Becloforte 2 puffs B.D.	<input type="checkbox"/>
- Oral Prednisolone 40 mg OD (1 week)	<input type="checkbox"/>
7	

- 1 British Thoracic Society. Guidelines for the management of asthma in adults: II-acute severe asthma. *BMJ* 1990; **301**:797-800.
- 2 British Thoracic Society, Research unit of the Royal College of Physicians of London, King's Fund centre and National Asthma Campaign. Guidelines for the management of asthma in adults. *Thorax* 1993; **48**(suppl):S1-24.
- 3 Reed S, Diggle S, Cusley MJ, Sleet RA, Tattersfield AE. Assessment and management of asthma in an accident and emergency department. *Thorax* 1985;**40**:897-902.
- 4 Ebdon P, Carey OJ, Quinton D, Codtson JB. A study of acute asthma in the accident and emergency department. *Br J Dis Chest* 1988;**82**:162-7.
- 5 Neville RG, Clark RC, Hoskins G, Smith B for general practitioners in Asthma Group. National asthma audit 1991-2. *BMJ* 1993;**306**:559-62.
- 6 Meighan JM, Mak VHF, Williams DJ, Bateman NT. Management of acute asthma in the A&E department: how practical are the BTS guidelines? [abstr] *Thorax* 1993;**48**:1064P.
- 7 Wrenn K, Rodewald L, Lumb E, Slovis C. The use of structured, complaint specific patient encounter forms in the Emergency Department. *Ann Emerg Med* 1993; **22**:805-12.
- 8 Town I, Kwong T, Holst P, Beasley R. Use of a management plan for the treatment of asthma in an Emergency Department. *Thorax* 1990;**45**:702-4.
- 9 Cochrane GM, Clark TJH. A survey of asthma mortality in patients between ages 35 and 64 in the Greater London hospitals. *Thorax* 1975;**30**:300-5.
- 10 British Thoracic Association. Death from asthma in two regions of England. *BMJ* 1982;**285**:1251-5.
- 11 Robin ED. Death from bronchial asthma. *Chest* 1988; **93**:614-8.
- 12 Wareham NJ, Harrison BDW, Jenkins PF, Nicholls J, Stableforth DE. A district confidential enquiry into deaths due to asthma. *Thorax* 1993;**48**:1117-20.

Injury Research Group

The 1996 annual meeting will be held in Manchester on 1-2 April. There will be a session of free communications and symposia on wound healing and on the psychological and psychiatric consequences of trauma. For details please contact:

Dr R N Barton
 North Western Injury Research Centre
 Stopford Building
 University of Manchester
 Oxford Road
 Manchester M13 9PT
 (Telephone 0161-275 5188, fax 0161-275 5190)

two months of being a patient on the observation ward. All patients had a score of at least 4, reflecting at least a medium risk. We suggest that an objective scoring system such as the SAD PERSONS score, admission to an A&E observation ward, and a multidisciplinary team review is a pertinent way of managing patients who present to the A&E department with episodes of deliberate self harm requiring admission who do not need significant medical or surgical input.

We recognise that the A&E department has a significant role to play in treating patients with deliberate self harm and has the potential to prevent some suicides. It is undesirable that any patient who has been through the system with an episode of deliberate self harm should later commit suicide, but following review of their records we have been unable to see what further action we could have taken to prevent their subsequent suicide. It is difficult to see how much more the A&E department can contribute to reducing the rate of suicide by the 15% recommended by the *Health of the nation* White Paper. We wonder if recent attendance at an A&E department with deliberate self

harm should be considered as a predictor of suicide and whether more assertive community outreach from the mental health service could improve the outcome in the high risk group.

- 1 Hockberger RS, Rothstein RJ. Assessment of suicide potential by non psychiatrists using the SAD PERSONS score. *J Emerg Med* 1988;6:99-107.
- 2 Hawton K, Fagg J. Suicide, and other causes of death, following attempted suicide. *Br J Psychiatry* 1988; 152:359-66.
- 3 Nordentoft M, Breum L, Munck L, Nordestgaard A, Hunding A, Bjaeldager P. High mortality by natural and unnatural causes: a 10 year follow up study of patients admitted to a poisoning treatment centre after suicide attempts. *BMJ* 1993;306:1637-40.
- 4 Secretary of State for Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992.
- 5 Adelstein A, Mardon C. Suicides 1961-74. In: *Population trends* vol 2. London: HMSO, 1975:13-18.
- 6 Gardner R, Hanka R, Roberts SJ, Allon-Smith JM, Kings AA, Nicholson R. Psychological and social evaluation in cases of deliberate self-poisoning seen in an accident department. *BMJ* 1982;284:491-3.
- 7 Greer S, Bagley C. (1971) Effect of psychiatric intervention in attempted suicide: a controlled study. *BMJ* 1971; i:310-12.
- 8 Lintner CM. Psychiatric involvement in cases of deliberate self harm. *Br J Soc Clin Psychiatry* 1985;3:11-15.
- 9 Owens DW, Jones SJ. The accident and emergency department management of deliberate self-poisoning. *Br J Psychiatry* 1988;152:830-3.
- 10 Owens D. Self-harm patients not admitted to hospital. *J R Coll Physicians Lond* 1990;24:281-3.
- 11 Driscoll P, Bryce G. The use of short-stay wards. A survey of 1,000 admissions. *Health Bull* 1987;45/6:294-302.

9th Annual Trauma Anaesthesia and Critical Care Symposium

Sponsored by International Trauma Anaesthesia and Critical
Care Society

Royal College of Surgeons of England
Lincoln's Inn Fields
London WC2A 3PN

For further information contact: Ms Sally Jenner, Association
of Anaesthetists of Great Britain and Ireland, 9 Bedford
Square, London WC1B 3RA. (Tel 0171 631 1650.)

paediatric departments. More work is required for application to the care of observation ward patients and, for that matter, to that of patients waiting for long periods in the A&E department before admission.

The team from the National Case Mix Office needs help from departments with detailed resource use data suitable for analysis. We would also like to see a uniform triage scale in use, as it may be possible to improve discrimination of the case mix measure by introducing a further breakdown according to urgency. The Clinical Services Committee of the British Association for Accident and Emergency Medicine is seeking to develop an acceptable triage scale for use in this country. A further useful measure may be derived from data about procedures used in the care of particular patients. The project is continuing and we hope for the support of colleagues both in volunteering useable data about the work of their departments and in being willing to pilot our initial casemix scale, when it becomes available.

Appendix

The members of the Accident and Emergency Medicine Casemix Working Group:

For the BAEM:

- Mr Jonathan Marrow, Merseyside (chair)
- Mr Nigel Brayley, Colchester (lead clinician)
- Dr John Gosnold, Hull
- Mr Peter Freeland, West Lothian
- Mr Stephen Miles, London

For the NCMO:

- Dr Hugh Sanderson (Director of NCMO)
- Mr Phil Anthony (statistical advisor)
- Ms Penny Bray (project manager)
- Ms Lisa Blayden (statistical advisor)

- 1 Sanderson H, Storey A, Morris D, McNay R, Robson M, Loeb J. Evaluation of diagnosis related groups in the National Health Service. *Community Med* 1989; 11:269-78.
- 2 Buckland RW. Healthcare resource groups: a more sensitive and less costly approach to contracting. *BMJ* 1994;308:1056.
- 3 Jelinek J. *A casemix information system for Australian hospital emergency departments*. Report to the Commissioner of Health, Health Department of Western Australia, Perth, 1992.
- 4 Brayley N. *Iso-resource grouping project*. Final report to the Department of Health, 1993. (Unpublished research findings. Data obtainable from the author.)

The Faculty of Accident and Emergency Medicine

SPECIALTY EXAMINATION

The first Faculty specialty examination in accident and emergency medicine will be held on 3/4 October 1996 at the Royal College of Physicians and Surgeons of Glasgow.

Regulations and application forms are available from:

**The Secretariat
Intercollegiate Specialty Boards
3 Hill Square
Edinburgh
EH8 (DR)
Tel: 0131 662 9222
Fax: 0131 662 9444**

**The closing date for receipt of applications is
9 August 1996**

Fee - £500

Detection of aluminium ring pulls

EDITOR – I was interested in the article on hand held metal detector location of aluminium ring pulls by Ryan *et al.*¹ The use of such detectors may be extended to include other metal containing foreign bodies, whether or not they are expected to be radio-opaque. Presence of the foreign body is detected more sensitively by the metal detector than by plain radiographs, and localisation to the stomach or lower gastrointestinal tract permits conservative management without confirmatory radiographs.²

This has particular advantages for children, who tend to swallow a large variety of objects and in whom radiation should be avoided if possible. The cost of such a hand held metal detector would be quickly recouped once five or so radiographs had been avoided.

F DAVIES

*Department of Accident and Emergency Medicine
Royal Liverpool University Hospital
Prescot Street, Liverpool, UK*

- 1 Ryan J, Perez-Avila CA, *et al.* Using a metal detector to locate a swallowed ring pull. *J Accid Emerg Med* 1995;12:64–5.
- 2 Sacchetti A, Carracchio C, Lichenstein R. Hand-held metal detector identification of ingested foreign bodies. *Paediatr Emerg Care* 1994;10:204–7.

Finding and removing small foreign bodies: a new technique for A&E

EDITOR – The removal of small calibre foreign bodies such as needles and splinters of wood

is a recurring difficulty in the accident and emergency (A&E) department. The time when foreign body removal should be at its easiest is when there is a fresh wound and tract. Removal should result in quicker wound healing and fewer complications. Even if the presence of a radio-opaque foreign body is known there is still the problem of finding and removing it.

I propose a simple method for detecting and removing small calibre foreign bodies which is suitable for use in the A&E department. It has not been described before. I have used it on 12 occasions and have succeeded in completely removing the foreign body on 11 of them. The only “failure” was in a patient with three fragments of glass in a finger tip, where two larger pieces were found and removed but the third, measuring about 1 mm in diameter, was not found. This piece was left in situ and caused no symptoms. Two typical examples of the use of this technique are presented.

TECHNIQUE

The technique simply involves identification of the tract by wiggling a piece of 1/0 or 2/0 nylon down through the entry point until it reaches the foreign body. The piece of nylon is held between the index finger and thumb. While rubbing it between the finger and thumb, push it into the wound so that it rotates and follows the tract made by the foreign body. It is usually easy to feel the nylon make contact with the foreign body. The nylon probe is left in the wound tract, which can then be opened by cutting from the entry point alongside the nylon until the foreign body is reached. It can then be easily removed.

I have only used the technique where the foreign body has been lying in the sub-cutaneous tissues, not in muscle.

Case 1

A 13 year old boy fell while playing football, causing a small skin puncture on the medial aspect of the knee. No foreign body was palpable and soft tissue *x* rays were normal, but the patient felt that there was something in the wound. Under local anaesthesia and using the method described an 8 mm thorn was identified and removed.

Case 2

A 38 year old electrician was hit on the left shin by a piece of fast moving metal from the chisel of a colleague, causing a small puncture wound. No foreign body was palpable but soft tissue *x* rays showed that a fragment of metal measuring 4 × 1 mm was lying between tibia and the skin. Using the method described the piece of metal was identified and removed.

The piece of nylon is as narrow as most needles, strong enough to be pushed without bending, but weak enough not to create its own tract. Although foreign body removal is easiest when the wound is fresh, this method has been used successfully up to two days later; removal of surface clot may reveal an easy to follow tract.

A LANNIGAN

*Accident and Emergency Department
Middlesborough General Hospital
Middlesborough, Cleveland, UK*

Institution of Engineers of Ireland

Impact Biomechanics, Injury & Traffic Safety

One week conference, 9–13 September 1996. Venue: Dublin

The aim of the programme is to bring the latest research on the biomechanics of impact injury to a wider technical and medical audience. It is only by achieving an understanding of how injury is caused that researchers and engineers can devise methods of mitigating injury severity. This one-week conference will bring to Ireland the world's leading experts in the areas of **traffic safety, injury, and trauma**.

The programme consists of three events: (1) A course on Impact Biomechanics and Injury; (2) A public “Manning” lecture, and (3) the hosting in Dublin by the Institute of Engineers of Ireland of the 1996 International IRCOBI Conference.

Further details from: Dr Christine Somers, Director of Education, Institution of Engineers of Ireland, 22 Clyde Road, Ballsbridge, Dublin 4, Ireland.

(Fax number +353 1 668 5508.)

