ative recovery. Ryan’s paper is important not just for the proposal of accelerated transfer of patients out of the A&E department but also for its clear demonstration that A&E department staff are, with or without a fast tracking system, the key agents in assuring that these priorities are tackled.

The primary problem for elderly patients with femoral fractures is, of course, not the location of, but rather the quality of, their wait for definitive care. The universal scarcity of beds is of fundamental concern to us all at the present time, but it is something over which clinical staff in A&E departments have little control and which we believe is too often used as an excuse for poor immediate care. In our departmental policy, for instance, patients with suspected proximal femoral fractures are given opiates in a judicious manner (rather than the non-steroidal medication described in Ryan’s article, which is associated with acute renal impairment and other serious complications in the elderly). We also prefer the three-in-one (“triple nerve”) block which anaesthetises the femoral, obturator, and lateral cutaneous nerves and just not the femoral nerve as was the case in 17% of Ryan’s patients), which then permits comfortable splintage and transfer to a bed. Alternatively, we transfer such patients directly from ambulance stretchers to beds which are “borrowed” if necessary from our short stay observation ward (SSOW) but which could, in other hospitals, be borrowed from the closed wards that clinicians in A&E trust.

In short, then, Ryan et al are to be applauded for establishing a system to reduce delays in transfer but, while frustrating bed shortages and delays in transfer around, they should not have an exaggerated bearing on the provision of timely, effective, and compassionate care in the A&E department.

Emergency medicine at a large rock festival

EDITOR,—We were very interested to read the experience of Hewitt, Jarret and Winter at the recent “rock festival” (FEILE’95) and were concerned to note the absence of notification to the Medical Journal of any injury which might have been sustained on the premises.

The primary problem for elderly patients with femoral fractures is, of course, not the location of, but rather the quality of, their wait for definitive care. The universal scarcity of beds is of fundamental concern to us all at the present time, but it is something over which clinical staff in A&E departments have little control and which we believe is too often used as an excuse for poor immediate care. In our departmental policy, for instance, patients with suspected proximal femoral fractures are given opiates in a judicious manner (rather than the non-steroidal medication described in Ryan’s article, which is associated with acute renal impairment and other serious complications in the elderly). We also prefer the three-in-one (“triple nerve”) block which anaesthetises the femoral, obturator, and lateral cutaneous nerves and just not the femoral nerve as was the case in 17% of Ryan’s patients), which then permits comfortable splintage and transfer to a bed. Alternatively, we transfer such patients directly from ambulance stretchers to beds which are “borrowed” if necessary from our short stay observation ward (SSOW) but which could, in other hospitals, be borrowed from the closed wards that clinicians in A&E trust.

In short, then, Ryan et al are to be applauded for establishing a system to reduce delays in transfer but, while frustrating bed shortages and delays in transfer around, they should not have an exaggerated bearing on the provision of timely, effective, and compassionate care in the A&E department.

Emergency medicine at a large rock festival

EDITOR,—We were very interested to read the experience of Hewitt, Jarret and Winter at the recent “rock festival” (FEILE’95) and were concerned to note the absence of notification to the Medical Journal of any injury which might have been sustained on the premises.

The primary problem for elderly patients with femoral fractures is, of course, not the location of, but rather the quality of, their wait for definitive care. The universal scarcity of beds is of fundamental concern to us all at the present time, but it is something over which clinical staff in A&E departments have little control and which we believe is too often used as an excuse for poor immediate care. In our departmental policy, for instance, patients with suspected proximal femoral fractures are given opiates in a judicious manner (rather than the non-steroidal medication described in Ryan’s article, which is associated with acute renal impairment and other serious complications in the elderly). We also prefer the three-in-one (“triple nerve”) block which anaesthetises the femoral, obturator, and lateral cutaneous nerves and just not the femoral nerve as was the case in 17% of Ryan’s patients), which then permits comfortable splintage and transfer to a bed. Alternatively, we transfer such patients directly from ambulance stretchers to beds which are “borrowed” if necessary from our short stay observation ward (SSOW) but which could, in other hospitals, be borrowed from the closed wards that clinicians in A&E trust.

In short, then, Ryan et al are to be applauded for establishing a system to reduce delays in transfer but, while frustrating bed shortages and delays in transfer around, they should not have an exaggerated bearing on the provision of timely, effective, and compassionate care in the A&E department.

Emergency medicine at a large rock festival

EDITOR,—We were very interested to read the experience of Hewitt, Jarret and Winter at the recent “rock festival” (FEILE’95) and were concerned to note the absence of notification to the Medical Journal of any injury which might have been sustained on the premises.

The primary problem for elderly patients with femoral fractures is, of course, not the location of, but rather the quality of, their wait for definitive care. The universal scarcity of beds is of fundamental concern to us all at the present time, but it is something over which clinical staff in A&E departments have little control and which we believe is too often used as an excuse for poor immediate care. In our departmental policy, for instance, patients with suspected proximal femoral fractures are given opiates in a judicious manner (rather than the non-steroidal medication described in Ryan’s article, which is associated with acute renal impairment and other serious complications in the elderly). We also prefer the three-in-one (“triple nerve”) block which anaesthetises the femoral, obturator, and lateral cutaneous nerves and just not the femoral nerve as was the case in 17% of Ryan’s patients), which then permits comfortable splintage and transfer to a bed. Alternatively, we transfer such patients directly from ambulance stretchers to beds which are “borrowed” if necessary from our short stay observation ward (SSOW) but which could, in other hospitals, be borrowed from the closed wards that clinicians in A&E trust.

In short, then, Ryan et al are to be applauded for establishing a system to reduce delays in transfer but, while frustrating bed shortages and delays in transfer around, they should not have an exaggerated bearing on the provision of timely, effective, and compassionate care in the A&E department.

Emergency medicine at a large rock festival

EDITOR,—We were very interested to read the experience of Hewitt, Jarret and Winter at the recent “rock festival” (FEILE’95) and were concerned to note the absence of notification to the Medical Journal of any injury which might have been sustained on the premises.

The primary problem for elderly patients with femoral fractures is, of course, not the location of, but rather the quality of, their wait for definitive care. The universal scarcity of beds is of fundamental concern to us all at the present time, but it is something over which clinical staff in A&E departments have little control and which we believe is too often used as an excuse for poor immediate care. In our departmental policy, for instance, patients with suspected proximal femoral fractures are given opiates in a judicious manner (rather than the non-steroidal medication described in Ryan’s article, which is associated with acute renal impairment and other serious complications in the elderly). We also prefer the three-in-one (“triple nerve”) block which anaesthetises the femoral, obturator, and lateral cutaneous nerves and just not the femoral nerve as was the case in 17% of Ryan’s patients), which then permits comfortable splintage and transfer to a bed. Alternatively, we transfer such patients directly from ambulance stretchers to beds which are “borrowed” if necessary from our short stay observation ward (SSOW) but which could, in other hospitals, be borrowed from the closed wards that clinicians in A&E trust.

In short, then, Ryan et al are to be applauded for establishing a system to reduce delays in transfer but, while frustrating bed shortages and delays in transfer around, they should not have an exaggerated bearing on the provision of timely, effective, and compassionate care in the A&E department.
Nurse practitioners

EDITOR,—Freij et al have shown that nurse practitioners are as good as senior house officers at deciding which minor trauma patients should be x-rayed and whether those x-rays show a fracture. Unfortunately there is a lot more to the management of these patients than the requesting and interpretation of x-rays.

In particular their correct management often requires a detailed knowledge of anatomy, physiology, pathology, and pharmacology. In addition about 15% of these patients will have a coincidental medical condition which will often affect the management of their injury. Others will have social circumstances that must be considered. It is therefore clear that only medical practitioners have sufficient training to manage minor trauma patients properly. Freij’s findings lead us nowhere.

A M LEAMAN
Accident and Emergency Department,
Princess Royal Hospital,
Telford, Shropshire

An unusual site to find a “swallowed” foreign body

EDITOR,—A 43 year old DIY enthusiast presented to casualty complaining that he swallowed a nail he had been holding between his teeth, which he felt had lodged at the back of his throat. He had made himself gag several times without any improvement in his symptoms. Oropharyngeal examination and indirect laryngoscopy were unremarkable. However, the lateral neck radiograph showed the nail lying on the floor of the nose (see the figure).

Impacted foreign bodies are most commonly found in the tonsillar area, and only 25% of foreign bodies impact below the hypopharynx. Symptoms are notoriously unreliable at predicting whether a foreign body is actually present. In this case his forced gagging had presumably regurgitated the nail through the choana, and the nail was removed uneventfully.

M A L C O M H I L T O N
Accident and Emergency Department,
Frenchay Hospital, Bristol

References


