2nd AUSTRALIAN INTERNATIONAL EMERGENCY NURSING CONFERENCE

"Proud of Our Past . . . Confident of Our Future"

8, 9, 10 & 11 October 1996,
The Hilton Hotel, Sydney, Australia

For Conference brochure contact:
Conference Secretariat, Emergency Nurses Association of NSW
PO Box 953, Parramatta, NSW, Australia 2124
Tel/fax: + 61 2 688 4937 or + 61 473 32400

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### FACULTY OF ACCIDENT AND EMERGENCY MEDICINE

#### Consultant Appointments January–April 1996

<table>
<thead>
<tr>
<th>Name</th>
<th>Post</th>
<th>Hospital</th>
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<tbody>
<tr>
<td>Mr B Al-Wakeel</td>
<td>Consultant in A &amp; E</td>
<td>Kingston Hospital</td>
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<tr>
<td>Mr J Binchy</td>
<td>Consultant in A &amp; E</td>
<td>Derriford Hospital, Plymouth</td>
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<tr>
<td>Dr T Brown</td>
<td>Consultant in A &amp; E</td>
<td>St Helens and Knowsley</td>
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<tr>
<td>Mr C J Cahill</td>
<td>Consultant in A &amp; E</td>
<td>Queen Alexandra Hospital, Cosham</td>
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<tr>
<td>Dr S Crowder</td>
<td>Consultant in A &amp; E</td>
<td>Warrington Hospital</td>
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<tr>
<td>Mr S Durham</td>
<td>Consultant in A &amp; E</td>
<td>Royal Lancaster Infirmary</td>
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<tr>
<td>Dr R J Evans</td>
<td>Consultant in A &amp; E</td>
<td>Cardiff Royal Infirmary</td>
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<tr>
<td>Mr Adrian Fogarty</td>
<td>Consultant in A &amp; E</td>
<td>The Royal Free Hospital</td>
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<tr>
<td>Mr V Gautam</td>
<td>Consultant in A &amp; E</td>
<td>Queen Elizabeth Hospital, Welwyn Garden City</td>
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<tr>
<td>Mr R Goel</td>
<td>Consultant in A &amp; E</td>
<td>Kingston Hospital</td>
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<tr>
<td>Ms R Johnson</td>
<td>Consultant in A &amp; E</td>
<td>Worcester Royal Infirmary</td>
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<tr>
<td>Dr S I Kitchen</td>
<td>Consultant in A &amp; E</td>
<td>Scunthorpe and Goole Hospitals</td>
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<tr>
<td>Ms P Longstaff</td>
<td>Consultant in A &amp; E</td>
<td>Chelsea and Westminster</td>
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<tr>
<td>Dr O Marzouk</td>
<td>Consultant in A &amp; E</td>
<td>Alder Hey Children’s Hospital, Liverpool</td>
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<tr>
<td>Ms F Moore</td>
<td>Consultant in A &amp; E</td>
<td>Charing Cross Hospital</td>
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<tr>
<td>Mr S W Payne</td>
<td>Consultant in A &amp; E</td>
<td>Ealing Hospital</td>
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<tr>
<td>Dr B Phillips</td>
<td>Consultant in A &amp; E</td>
<td>Alder Hey Children’s Hospital, Liverpool</td>
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<tr>
<td>Mr F Richardson</td>
<td>Consultant in A &amp; E</td>
<td>Downshire Hospital, Northern Ireland</td>
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<tr>
<td>Mr B Sinnoff</td>
<td>Consultant in A &amp; E</td>
<td>Newham Healthcare Trust</td>
</tr>
<tr>
<td>Mr A Soorma</td>
<td>Consultant in A &amp; E</td>
<td>St Helier NHS Trust, Carshalton</td>
</tr>
<tr>
<td>Mr S Suleman</td>
<td>Consultant in A &amp; E</td>
<td>Northern General, Sheffield</td>
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<tr>
<td>Mr B Tesfayohannes</td>
<td>Consultant in A &amp; E</td>
<td>North Tees General Hospital</td>
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<tr>
<td>Mr S Wadhani</td>
<td>Consultant in A &amp; E</td>
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specialists. It is accepted, however, that in any study such as this there is considerable inter-rater variability. The inconsistency in this study arose not simply because of opposing opinions, but was due to the nature of the dataset. Necropsy records detail the presence of haematoma and cerebral injury, but only describe the volume and location of such injuries in general terms. The non-neurosurgical assessors were more ready to assign a case to either the "potential survivor" or "definite death" group rather than classify as "insufficient information", resulting in levels of agreement of only three out of four assessors. In almost all of these cases the neurosurgeon gave the most optimistic opinion as it was felt that the haematoma or cerebral injury could not be taken into account without more information on its extent.

This study considers only deaths from major trauma and the potential impact of improved prehospital care on these. It is suggested that the reduction in mortality may not be so great as has been hoped, as has previously been suggested. However, we have excluded deaths from drowning, electrocution, poisoning, asphyxia, and hypothermia and this may be the field where these services could have the greatest effect in reducing unnecessary mortality.

have to be monitored carefully. The approach, access, and parking facilities for both ambulances and private vehicles will have to be reviewed in the A&E department to accommodate the increasing majority of patients who are arriving by ambulance or private cars. 

CONCLUSIONS

The comparison of 1993 and 1994 attendances with 1990 attendances in this A&E department show an increasing number of patients, who are older, more likely to be admitted, and present through the ambulance service or by private transport. The A&E department is an important interface between the hospital and the community. It is a vital and economically influential component of the health care received, especially by the elderly population. Current demographic predictions coupled with data on the patterns of A&E attendances have logistic and financial implications for purchasers of health care in terms of expected future demand. For providers, these trends must influence the planning of future A&E services with special emphasis upon the care provided for the elderly population. It is essential that both purchasers and providers plan future health care well in advance, implementing well informed change to maintain a high quality service.

5 Court C. Rising emergency admissions disrupt NHS. BMJ 1994;309:1322.

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
Table 2  A comparison of the rate of x ray for ankle injury during this study with that at different times outside the study

<table>
<thead>
<tr>
<th></th>
<th>Ankle injury</th>
<th>X ray</th>
<th>Fracture seen (% of x rays)</th>
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<tbody>
<tr>
<td>Jan (last month of SHOs' contract)</td>
<td>202</td>
<td>114 (56%)</td>
<td>24 (21%)</td>
</tr>
<tr>
<td>Aug (first month of SHOs' contract)</td>
<td>207</td>
<td>136 (65%)</td>
<td>18 (13.3%)</td>
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<tr>
<td>During study (3 month period)</td>
<td>464</td>
<td>332 (72%)</td>
<td>64 (20%)</td>
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</table>

of ankle x ray found when the new senior house officers began work in the following August.

Discussion

The history of a crack noise or sensation associated with ankle injury is not uncommon: it was volunteered in 104 patients (22%) and admitted to on direct questioning by a further 38 patients (8%). Although a "crack history" has never been suggested as an indication for x ray, this study suggests that it has been taken as such an indication. This may well reflect patient expectations. However, the converse appears to be the case, that is, the presence of a positive crack history suggests that a fracture is less likely to be present. This being the case, it may be that such patients require more counselling about the nature and management of their injuries, rather than the often more expedient but decidedly more expensive alternative of radiology.

The source of the cracking sound or sensation is not ascertained but could be due to soft tissue tearing. This is well described as a symptom in Achilles tendon rupture. Thus the presence of this symptom could actually be suggestive of soft tissue injury and thus reduce the need for x rays in the absence of other clinical indications for radiology. In this study we did not look specifically for evidence of ankle instability which might be a consequence of ligamentous damage and this aspect may warrant further investigation.


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.)
issue. The precise format of the casualty record forwarded to the GP presents difficulties. The green form must contain more than just the essential summary details required by GPs as it is often the only basis from which to defend a complaint against the A&E department. The alternative of posting a computer generated letter to GPs also has drawbacks. Such letters are generated by diagnostic coding; the quality of the letter is only as good as that of the coding. GPs may receive letters that are inaccurate or late, and there may not be the facility for free text.

The department aims to send a short typed summary on the 18% or so of attenders that have been discharged from the follow up clinic. It is disappointing that only 28/90 (31%) of GPs reported always/usually receiving this communication but this may in part reflect the relative infrequency of an individual GP's patient attending the clinic. At least 96% of those able to comment indicated that these letters contained about the right amount of information.

CONCLUSION
We conclude that a postal survey of local GPs can give valuable information about the quality of care provided by a hospital department. Overall GP satisfaction with the service was high, but there are concerns about aspects of written and telephone communications between the department and GPs, which can be addressed.

We are grateful to Sandra Mulligan, Steve Stoker, and Nick Lazenby from the Royal Victoria Infirmary Clinical Audit Office for data analysis, and to Laura Johnstone for secretarial support.


Referees for the Journal of Accident & Emergency Medicine

All papers submitted for publication in the Journal of Accident & Emergency Medicine undergo peer review. As a result of the continuing rise in the number of papers received the Journal seeks additional referees.

This is an interesting and stimulating activity. The Editorial Office ensures that the workload for referees is not onerous and guidelines are provided to allow a structured critique of each paper. Referees are expected to return comments within three weeks of receipt of the manuscript.

Please contact the Editor, Journal of Accident & Emergency Medicine at BMA House, Tavistock Square, London WC1H 9JR, telephone 0171-383-6795, fax. 0171-383-6668, stating your present appointment and any areas of special expertise. Reviewers are particularly welcome from other specialties with an interest in Emergency Medicine and from outside the U.K.
The detailed anatomy of the interphalangeal joint of the hallux has been well described previously.\(^1\)

With a Medline search we were unable to find any reports of sesamoid entrapment as a complication of closed manipulation of a dislocated interphalangeal joint of the hallux.

The recommended treatment for sesamoid interposition should be the same as for entrapment from the outset, with a trial of closed manipulation and reduction.\(^7\) Open reduction will be required for failure of closed reduction.\(^1\)

An immobilisation splint is recommended for six weeks to prevent recurrence of the interposition.\(^1\)

Post-reduction radiographs are essential and in this case may have helped to prevent long term complications for the patient. Post-reduction radiographs are routine after all manipulations in our department and this is in agreement with recently published guidelines.\(^8\)


\(^4\) Muller GM. Dislocation of sesamoid of hallux. Lancet 1944;i:789.


