The authors reply

Dr Brooks raises a very important point concerning the transmission of clinical information about patients who are passing from the care of one doctor (unit, hospital) to another. In this example the patient is passing from A&E to an inpatient unit. There is concern that the doctor in the ward may not realise how ill the patient is because there has been no opportunity to see the condition of the patient in the A&E department. With very sick and unstable patients it is the responsibility of the A&E doctor to telephone the ward doctor at the time of admission and give a full verbal report on the patient’s condition and the treatment given.

Changing medical practice means that hospital patients are very frequently cared for by several medical disciplines at the same time, for example, the diabetic patient with peripheral vascular disease or the multiply injured patient. In addition the junior doctor in the A&E department investigated the patient’s condition of injury and, before the patient was passed on to the ward, the junior doctor telephoned the ward doctor and gave a full verbal report on the patient’s condition and the treatment given.

Asthma management

Editors—Regarding the article by Robinson et al.1 in the March issue, an audit carried out in our department has investigated a simpler approach to improving asthma management. We introduced a stamp on the A&E cards of all asthma attendances (see the figure) to prompt doctors to record peak flow values and refer to departmental guidelines based on those published by the British Thoracic Society.2

INITIAL PFR

\[ \begin{array}{c}
\text{MIN} \\
\text{DOCTOR'S PREDICTED PFR} \\
\text{\%} \\
\text{NOW REFER TO ASTHMA CHART}
\end{array} \]

Stamp used on the A&E cards of asthma attendances.

The A&E notes of 80 successive asthmatic attendances were reviewed for details of peak flow recording, investigation, management, and follow up before and after the intervention. Improvements were achieved in recording peak flow at presentation (84% v 97.5%), predicted peak-flow (21% v 75%) and in sending a GP letter (21% v 39%). However, we failed to improve prescription of steroids on discharge (36% v 58.5%).

If “inappropriate discharge” is defined as the discharge of a patient with a presenting peak flow of less than 50% of predicted (the BTS guidelines2 advise admission in such cases) and alter the measurement 43% of such cases were discharged after the audit compared to 38% before. Further analysis of these cases revealed that most had markedly improved with nebuliser administration, the mean post-nebuliser peak flow being 80% of predicted. Whether this justifies discharge is debatable but it clearly does not follow national guidelines.

The improvements in peak flow recording we obtained are strikingly similar to those obtained by Robinson et al and indicate that simple alterations to the A&E card are all that is required to optimise recording of this essential variable in asthma management. However, their comparative success in reducing the number of inappropriate discharges suggests that the preprinted form is of greater value in ensuring adherence to clinical guidelines.

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Management of drug overdoses

Editors—We were interested in the recent paper on the management of drug overdoses by Greaves et al.1 Our experience of these treatment variations are similar. Additionally, we have been getting inconsistent advice from different Poison Information Centres. We therefore carried out a small study to assess the consistency of advice given by the Poison Information Centres.

We used five of the same scenarios used by Greaves. These are as follows:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Poison Information Centre 1</th>
<th>Poison Information Centre 2</th>
<th>Poison Information Centre 3</th>
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<tbody>
<tr>
<td>1</td>
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2 Management of acute paracetamol overdose. British Association for Accident and Emergency Medicine, June 1995.

Toddler’s fracture

Editors—We read the paper on “toddler’s fracture” by Shroff et al2 and congratulate them for raising the profile of this topic.

There are several aspects of the paper on which we wish to comment. When discussing fractures in young children there are two distinct clinical entities to be distinguished. The first is a child with a visible spiral fracture to the tibia or femur on initial presentation. We suggest this should be described as a “fracture in a toddler”. This is to be distinguished from the situation where no fracture is visible on initial, standard, good quality x-rays (and supported by a negative radiologist’s report) but where subsequent films, usually at 10-14 days after presentation, reveal a periosteal reaction alone or combined with a fracture line. The term “toddler’s fracture” should be reserved, in our opinion, for this latter situation in which a fracture only becomes detectable retrospectively (figure).

The term “missed fracture” is misleading when applied as described in the paper to fractures not detectable by a radiologist. There could obviously be medicolegal consequences with the use of such terminology for an injury which only becomes detectable radiologically on subsequent films.

The stated incidence of toddler’s fracture even as described is surprisingly low. Assuming child attendances at the Blackpool accident and emergency unit are 20%, we would expect the total figures, 15,000-18,000 children attend annually. There are 28,000 new attendances at Edinburgh’s Royal Hospital for Sick