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 reduction in junior doctors hours of work often results in patients being seen at night by a doctor who does not work in that unit during the day or who has the next day off.

Doctors usually communicate patient details to each other solely by written clinical notes. This is nearly always inadequate. Verbal communication provides different and usually more detailed information; it allows doctors to convey their general impressions about patients more easily and gives them the opportunity to ask each other questions and discuss each patient's management. We would do well to look to the nurses who realise that it is important at each change of staff—or when patients move to different departments—to have a verbal report on each patient in their charge.

Doctors need to set aside time to have a verbal handover of information about each patient in addition to what they have written.

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Asthma management

EDITOR,—Regarding the article by Robinson *et al*¹ in the March issue, an audit carried out in our department 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	<input type="text"/>	L MIN
NORMAL/PREDICTED PFR	<input type="text"/>	L MIN
% PREDICTED	<input type="text"/>	%
NOW REFER TO ASTHMA CHART		

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 described above.

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 (56% *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), then our intervention failed to alter this 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.²

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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- 1 Robinson SM, Harrison BDW, Lambert MA. Effect of a preprinted form on the management of acute asthma in an accident and emergency department. *J Accid Emerg Med* 1996;13:93-7.
- 2 British Thoracic Society. Guidelines for the management of asthma in adults: II-Acute severe asthma. *BMJ* 1990;301:797-800.

Management of drug overdoses

EDITOR,—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:

- (1) A 26 year old male who claims to have taken 100 paracetamol tablets one hour previously. He is a chronic attender who has taken many previous overdoses.
 - (2) A 19 year old male who has taken 30 paracetamol 500 mg tablets two hours previously. He has not vomited.
 - (3) An 18 year old female who took 20 diazepam 2 mg tablets two hours ago, after drinking half a bottle of vodka.
 - (4) A 43 year old female who has taken 20 amitriptyline 25 mg tablets four hours previously. She is tachycardic and sweaty.
 - (5) A 45 year old male who has taken 50 aspirin 300 mg tablets eight hours previously. He has nausea and tinnitus.
- Seven of the Poison Information Centres, which were unaware of the study, were telephoned with these scenarios. Their advice with regard to immediate management was noted (table).

It can be seen that advice given by the Poison Information Centres differs widely between centres. We compared the advice given regarding paracetamol overdose with the established national guidelines.² The majority of centres recommended lavage (with or without charcoal) but only a minority recom-

Drug overdose scenarios

Scenario	Lavage and charcoal	Charcoal	Levels	None
1	2	3	2	—
2	2	2	2	1
3	—	—	1	6
4	—	2	4	1
5	—	—	5	2

mended initiating treatment with oral methionine (two in scenario 1, three in scenario 2).

One centre advised starting treatment with N-acetylcysteine for scenario 1, which is not recommended in the national guidelines.

The efficiency of gastric lavage is often questionable, especially four hours after a significant tricyclic antidepressant overdose. This uncertainty is shown by the fact that two of the centres still recommended it in scenario 4.

Greaves showed variation in the management of drug overdoses by medical staff. We feel that this may be partly due to the variation of advice given by the different poison information centres. The problem could be addressed by wide circulation of more established national guidelines in the treatment of overdoses.

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- 1 Greaves I, Goodacre S, Grout P. Management of drug overdoses in accident and emergency departments in the United Kingdom. *J Accid Emerg Med* 1996;13:46-8.
- 2 Management of acute paracetamol overdosage. British Association for Accident and Emergency Medicine, June 1995.

Toddler's fracture

EDITOR,—We read the paper on "toddler's fracture" by Shravat *et al*¹ 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 20-25% of the total figures, 15 500-18 000 children attend annually. There are 28 000 new attendances at Edinburgh's Royal Hospital for Sick

Left: A 2 year old with limping and tenderness over the distal tibia. No abnormality is seen. Right: A fracture line [spiral pattern (a)] is now shown over the lower third of the tibia with periosteal reaction along the tibial shaft (b).

Children per year and we see 70 toddler's fractures (as defined above) each year.

In our experience not all these children require immobilisation of the limb in a plaster of Paris. We reserve such treatment for children when sleep or daily activities are disturbed by pain. In this age group the extra weight of an above knee cast for a parent to carry, combined with the hygiene challenge in a group either wearing nappies or being toilet trained, outweighs any advantage to the child except for analgesic purpose as stated above.

Any discussion on fractures in young children should include reference to non-accidental injury as the cause and we feel this should not have been omitted from this paper.

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1 Shrivast BP, Harrop SN, Kane TP. Toddler's fracture. *J Accid Emerg Med* 1996;13:59-61.

Fast tracking patients with a proximal femoral fracture

EDITOR,—In relation to the paper by Ryan *et al*¹ on "fast tracking" patients with proximal femoral fractures, we have operated a fast track system for proximal femoral fractures on and off for several years. In our system, uncomplicated cases, defined by a protocol, are received nurse requested radiology, the x rays, when returned, are briefly assessed by an A&E doctor, and the patient is then admitted directly to the ward and the orthopaedic SHO informed. If there is time in A&E and the department is not too busy, we will also cannulate the patient and do relevant blood tests and an ECG, but not invariably. This

system seems to work well. However, a recent audit showed disappointing results in that there were still unacceptable delays for some patients. The chief reasons for the delay were long periods spent in the x ray department and problems with unfamiliar orthopaedic junior staff refusing to accept patients on such a basis, and insisting on assessing them in the A&E department. This has now been addressed and the system will be reaudited soon.

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1 Ryan J, Ghani M, Staniforth P, Bryant G, Edwards S. "Fast tracking" patients with a proximal femoral fracture. *J Accid Emerg Med* 1996;13:108-110.

BOOK REVIEWS

Fundamentals of Emergency Radiology.

By Philip Wiest and Paul Roth. (Pp 175; £27.95.) Philadelphia: W B Saunders, 1996. ISBN 0 7216 5182 8.

This is a superbly illustrated text on emergency radiology and is aimed primarily at physicians and medical students involved in the emergency department. As its title indicates, it is not a definitive text on any of the areas covered but concentrates on practical aspects of selecting the most appropriate imaging techniques. This is facilitated by a number of excellent flow charts. These have been applied in each of the chapters, which include imaging of the head and spine, chest, abdomen, urinary tract, pelvis, and orthopaedics.

A number of useful "pearls" are enumerated at the end of each chapter, emphasising the most important points for the practising clinician. As indicated, the image quality is of the highest standard and unlike many texts the radiological abnormalities are easily visualised and well annotated.

There are a number of transatlantic idiosyncrasies which do not translate well to the British system. This may in part relate to the availability of high tech equipment. Other basic differences include their routine use of PA and lateral chest films for patients with chest pain, where a PA chest x ray in the first instance is considered adequate in most UK centres.

These are, however, minor differences of opinion which do not detract from what is an excellent, compact, easily readable text. I would recommend this to anyone starting in an emergency department; it may even be of use to trainee radiologists as it covers the basic groundwork of emergency radiology.

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Emergency Medical Therapy. By T F

Mengert, M S Eisenberg, and M K Copass. (Pp 992; £33.00.) Philadelphia: W B Saunders, 1996. ISBN 0 7216 5162 3.

This chunky little book wants to be a pocket manual for all known medical specialities. It's a big ambition for a relatively small book, but achieves it in the main. The problem is that if you are going to ruin your white coat pockets, it needs to be with a book that covers everything.

The majority of adult medical emergencies are covered, and the therapeutic options are presented in an easy to read and logical way. Some of the first line drugs are unfamiliar, or would not be first choice in this country, but there is lots of really practical advice on diagnostics as well as suggested starting doses and predicted response levels. Internal headings for chapters follow the same pattern throughout, and include pearls and pitfalls as well as suggestions on disposition of the patient. There are some helpful flow diagrams dealing, for example, with headaches or CNS symptoms in HIV infected patients. These are mixed with some more weighty and rather indigestible tables. The first chapter on general care of the emergency department patient could easily form the basis of the SHO induction talk.

The recurring theme is early assessment/resuscitation, followed by a more leisurely discourse on possible causes and remedies. Many of the chapters put me in mind of practice exam answers in their eagerness to follow a pattern and they would therefore be useful for revision. It also lends itself to a source of reference for emergency nurses in this country.

There are a few missing medical topics that I would have enjoyed reading the solution to—perhaps confusional states, and the care of the frail elderly. Additionally, although hand infections are addressed in great detail, little else is offered for the care of the "walking wounded". This is a pity because, judging from the section on conscious sedation, local anaesthetic techniques and blocks as well as wound care would have been usefully discussed.

Overall, I like this book but wish it was either smaller and lighter, or, by extending its scope to surgery/trauma cases, it could be a