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appropriate, and used clinical judgement to reduce the number of radiographs requested, though not as few as the American guidelines would have indicated.

Guidelines for admission were also not followed accurately, but not to the same extent as with skull radiography. Only 2.3% of patients were inappropriately discharged but we have no evidence that they came to harm. More encouragingly, only 0.7% of patients were inappropriately admitted. Our rate of admission was 8.6% (theoretically 10.3% needed admission), compared to between 13 and 25% in other studies.[6 7] It is therefore apparent that no substantial savings on resources would have been made if the guidelines for admission were adhered to completely.

It also becomes apparent that the use of guidelines demands constant reappraisal especially in A&E departments where junior staff changes every six months. The use of posters as a reminder of guidelines has been advocated and tried successfully in other departments.[8]

CONCLUSIONS

We conclude that the use of the British guidelines for skull radiography in children in our A&E department creates a large demand for radiography (63% of attenders). The use of the American guidelines appears to reduce the number of radiographs requested in children presenting with head injury, without apparent risk of missing significant injury or skull fracture. We therefore recommend the use of the American guidelines along with techniques for ensuring their uptake.

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survival, it must be a decision that is always taken by the most experienced and in line with peer reviewed guidelines. We need to develop and evaluate criteria for admission to ICU and CCU after cardiopulmonary arrest. The decision to keep a patient on the ward will critically affect outcome. This is a decision that should be taken by a consultant. We recommend strongly that the use of intensive care facilities in the postarrest period should be monitored far more closely and recommendations developed. Our findings are to be followed up with a more detailed study to include information on the underlying disease and the nature of the cardiopulmonary arrest.

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and enthusiasm of the staff at Frenchay Hospital, Bristol, and Western General Hospital, Western-super-Mare, in the making of this video, whose message is loud and clear that gone are the days when a motley crew would arrive at a cardiac arrest situation full of adrenergic ardour but devoid of well practiced coordinated clinical skills, with the result that a life potentially saved was all to often lost.

As a former member of that motley crew I am delighted that times have changed and that advanced life support should now be within the domain of all paramedical, nursing, and medical professionals. This video will be highly effective in promoting that message to the widest possible audience.

I W R ANDERSON
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The *Journal of Accident and Emergency Medicine* publishes articles on all aspects of emergency medicine. The emphasis is on original research of a high scientific standard. Papers also include review articles, short reports, case reports, and occasional papers dealing with specific aspects of emergency care. The Journal aims to represent all specialties involved in emergency care, both in the pre-hospital and in the hospital environment. It has an international readership, and articles reflecting the global perspective are particularly welcome. Authors are invited to submit any work that will contribute to the progress of emergency medicine worldwide.

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