Use and abuse of spinal boards

Editor,—I was interested to read the exchange of correspondence between Dr C J Carney and Drs Main and Lovell regarding the use and abuse of spinal boards. In their original paper and their letter, the authors draw attention to the dangers of prolonged use of a rigid spinal board. These concerns are certainly real, and I have even witnessed a patient still lying on a spinal board on an orthopaedic ward more than 24 hours after spinal injury had been ruled out by A&E staff. I would, however, disagree with the authors' interpretation of the term "extrication". Any removal of an injured patient from a vehicle constitutes extrication, whether the patient is trapped or not, and the authors' reference to entrapment misses the point set out by Dr Carney. While many injured patients may leave their vehicle of their own volition, or be assisted out by well meaning bystanders, patients with significant injuries will often remain inside the vehicle until the ambulance crew arrives. The way in which these patients are removed by rescuers can be crucial in preventing further injury, and the spinal board is one of the key tools in doing this. The methods are well known to most immediate care doctors and ambulance personnel.

We have recently tried out a useful adjunct to the spinal board—the Reeves sleeve. This sleeve is constructed of a padded plastic material and slips over the rigid spinal board. The padding renders the spinal board more comfortable for both patient and examiner, and the sleeve offers the advantage of six built-in patient straps and two head wedges with padded, head-restraining straps. The robust construction of the sleeve converts a spinal board into the equivalent of the old Neil-Robertson stretcher, and the combination can be used for mountain and building rescue as well as the more common everyday uses. Further information on this sleeve may be obtained in the United Kingdom from Aireshelta Ltd (Mr R Bailey, Tel: 01484-646559; Fax: 01484-644450).

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-current use of the A&E ward

Editor,—I wish to thank Rainer et al for their review of the current use of the accident and emergency ward as it relates to their caseload, but what of the future? There are increasing opportunities to use the A&E ward as a facility for intensive early investigation and treatment to prevent prolonged hospital stays when the patient is not in need of nursing care. For example, the following patients with uncontrolled deep vein thrombosis or with persistent haemorrhage may be admitted to the A&E ward on a non-emergency basis:


Prehospital cardiac arrest in Leicestershire

Editor,—I congratulate the authors of the paper on prehospital cardiac arrest published in the July 1996 issue of the Journal on their extensive analysis. However, in their paper they describe subgroups which I believe are possibly open to confounders. Specifically:

1. The influence of professional versus lay cardiopulmonary resuscitation (CPR). Professional CPR may imply the close proximity and early application of a defibrillator which is well known to improve prognosis. I wonder if the group was further analysed to ensure that the times to defibrillation for the professional CPR group versus the lay CPR group were similar.
2. Glasgow coma score as a prognostic indicator: the authors mentioned that the Glasgow coma score was used to determine suitability for intensive care. There is a possibility that the admission to intensive care itself may have influenced survival, thus improving the survival for those with a higher Glasgow coma score and confounding the use of the score as a prognostic indicator.

I believe clarification of these points would be of benefit if greater promulgation of basic life support skills and availability of defibrillators in the community are to be supported, and admissions to intensive care units rationalised.

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The authors reply:

Dr Cameron raises two important issues for clarification. Professional first responder CPR was defined as that given by medical, nursing, paramedical, or trained first aid responders. This occurred in 48 cases and often involved the patient's general practitioner who had been called before the 999 call, or off duty emergency medical services (EMS) staff. In no case was defibrillation used before the arrival of the ambulance. In fact when questioned, most GPs in Leicestershire stated that they do not carry a defibrillator, reasons given being expense, information, or some natures of the equipment, and skill levels required in using a defibrillator.

Our study confirms the findings of others that trend changes in the Glasgow coma score over the first 24 hours can be used as a good indicator of prognosis and a reason to continue or withdraw intensive support in...