LETTERS TO THE EDITOR

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 movement and gives the advantage of six inbuilt 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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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, I am aware of some hospitals now removing the artificial saphenous vein, iliac vein and iliac artery thrombosis in A&E, those amenable to outpatient management can be discharged within 24 hours receiving subcutaneous fractionated heparin (given once daily with no coagulation monitoring needed). A nurse practitioner organises continuing treatment in the community and outpatient follow up care. The patient will have their first dose of warfarin in A&E and receive the remainder of their loading doses in the community.

Patients with upper gastrointestinal bleeding and at low risk of rebleeding can have an endoscopic diagnosis from the A&E ward and where appropriate can be discharged home on treatment within 24 hours of arrival. Patients with ureteric colic may also be suitable for early discharge and outpatient follow up and thus benefit from a similar use of the ward.

There are these three current examples, there are more and more will arise in time. Their use will be determined by case mix and other factors affecting medical innovation adoption.

The advantages are not just the more economical use of acute beds but better quality of life for the patient.

It may be too much at present to seek radiological demonstration of DVT or endoscopy for low risk upper gastrointestinal bleeding (for example) at any time of day or night. These facilities could, however, be offered some time within a 24 hour period, seven days a week (my experience is that other specialists do not have to be convinced of the benefit of this). Hence the use of the A&E ward as a holding bay for these patients away from the busy areas of the department and the avoidance of formal admission to another specialty is beneficial. A&E should have these facilities if necessary. The duration of stay on the ward needs to be limited and the limits enforced. Is A&E going to take referrals with these conditions from GPs or even in house from on call specialists?

This case is a multidisciplinary process requiring agreement and coordination. A&E medicine is still of central importance. We have to take the lead. Procedures need to be agreed and information accessible to the attending doctors and nursing staff. Care pathways may be the best way to guide non-permanent junior medical staff who see the majority of such patients.

This surely, has to be a good use of an A&E ward (which has many uses) and with further improvements in technology and patient management systems is an increasingly important direction for the development of emergency care and A&E as a specialty.

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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, infrequent use, cumbersome nature 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