

	Age	MOI	Injury 1	AIS code 1	Injury 2	AIS code 2	X ray	Disposal
195	23	na	emotional distress				n	home
196	24	na	emotional distress				n	home
197	25	na	asthmatic				n	home
198	26	na	diabetic				n	home
199	26	na	emotional distress				n	home
200	28	na	emotional distress				n	home
201	29	na	emotional distress				n	home
202	34	na	epilepsy				n	home
203	43	na	angina				n	admitted
204	47	na	emotional distress				n	home
205	52	na	emotional distress				n	home
206	56	na	angina				y	admitted
207	58	na	asthma				n	home
208	74	na	emotional distress				n	home

y,yes; n,no; MOI,mechanism of injury; fg,flying glass; blunt,blunt trauma; dnw,did not wait; na,not applicable.

- American Association for Automotive Medicine. *The Abbreviated Injury Scale (AIS) 1990 revision*. Des Plaines, Illinois: AAAM, 1990.
- Cooper GJ. Casualties from terrorist bombings. *J Trauma* 1983;23:955-67.
- Adler J. Terrorist bombing experience during 1975-79. *Isr J Med Sci* 1983;19:189-93.
- Brismar B, Bergenwald L. The terrorist bomb explosion in Bologna, Italy, 1980: an analysis of the effects and the injuries sustained. *J Trauma* 1982;22:216-20.
- Hadden W, Rutherford W, Merret XX. The injuries of terrorist bombing: a study of 1532 consecutive patients. *Br J Surg* 1978;65:525-31.
- Tucker K, Lettin A. The tower of London bomb explosion. *BMJ* 1975;iii:287-89.
- Kennedy TL, Johnston GW. Civilian bomb injuries. *BMJ* 1975;ii:382-3.
- Scott BA, Fletcher JR, Pulliam MW, et al. The Beirut terrorist bombing. *Br J Neurosurg* 1986;1:107-10.
- Caro D, Irving M. The Old Bailey bomb explosion. *Lancet* 1973;ii:1433-5.
- Waterworth TA, Carr MJT. Report on injuries sustained by patients treated at the Birmingham General Hospital following the recent bomb explosions. *BMJ* 1975;ii:25-7.
- Rignault DP, Deligny MC. The 1986 terrorist bombing experience in Paris. *Ann Surg* 1988;209:368-73.
- Frykberg ER, Tepas J. Terrorist bombings. *Ann Surg* 1988;208:569-76.
- Rutherford W. Civil disturbances in Belfast. *Injury* 1972;4:189-99.
- Brown MG, Marshall SG. The Enniskillen bomb: a disaster plan. *BMJ* 1988;297:1113-6.
- Rutherford WH. Experience in the Accident and Emergency department of the Royal Victoria Hospital with patients from civil disturbances in Belfast 1969-1972, with a review of disasters in the United Kingdom 1951-1971. *Injury* 1972;4:189-99.
- Hodgetts TJ. Lessons from the Musgrave Park Hospital bombing. *Injury* 1993;24:219-21.
- Johnstone DJ, Evans SC, Field RE, Booth SJ. The Victoria bomb: a report from the Westminster Hospital. *Injury* 1993;24:5-9.
- Mallone S, Shariat S, Stennies G, Waxweiler R, Hogan D, Jordan F. Physical injuries and fatalities resulting from the Oklahoma City bombing. *JAMA* 1996;276:382-7.

British Association of Plastic Surgeons Advanced course in plastic surgery 6:2

The sixth meeting will be held on
4-5 April 1997 in Sheffield:

Hand 1. Trauma/peripheral nerve surgery

The course is aimed at consultants and trainees in plastic surgery but members of the British Association for Accident and Emergency Medicine are invited to attend. The fee will be £350.00, which includes one night's accommodation and all meals.

Further details and an application form are available from the British Association of Plastic Surgeons, The Royal College of Surgeons, 35-43 Lincoln's Inn Fields, London WC2A 3PN. Tel 0171 831 5161/2; fax 0171 831 4041.

whether ATLS awareness as well as ATLS provider status leads to a better standard of care. It has been shown before that ATLS training provides a comfortable framework for non-trauma-experienced physicians confronted with a major incident.⁹ We have also assessed people who have attended a one-day trauma course. While realising that performance during a simulation does not equate directly with performance in the real event, we feel that our simulation was as close to reality as was practically possible.

Within the limitations of this small study, the general trend was that clinicians with previous ATLS training, or exposure to ATLS principles, were more ordered in their approach to patient management and achieved higher assessment scores. Training along ATLS principles would appear to be beneficial and should be offered to all hospital staff in the way of one-day trauma courses. Those involved in the regular care of trauma victims should be encouraged to attend an ATLS course. This

should lead to improved trauma care not only under simulated major incident circumstances but also in day to day practice.

- 1 Williams MJ, Wass AR, Gibson MF. A review of the management of a major incident involving predominantly paediatric casualties. *Injury* 1994;25:371-4.
- 2 Hall DJ, Williams MJ, Wass AR. Life support course for all. *J Accid Emerg Med* 1995;12:111-4.
- 3 Advanced Trauma Life Support manual. American College of Surgeons, 1995. (Available as part of ATLS course material.)
- 4 Palmer SH, Maheson M. A radiological review of cervical spine injuries from an accident & emergency department: has the ATLS made a difference? *J Accid Emerg Med* 1995;12:189-90.
- 5 Burdett-Smith P, Airey M, Franks A. Improvements in trauma survival in Leeds. *Injury* 1995;26:455-8.
- 6 Vestrup JA, Stormorken A, Wood V. Impact of Advanced Trauma Life Support training on early trauma management. *Am J Surg* 1988;155:704-7.
- 7 Bennett JR, Bodenham AR, Berridge JC. Advanced Trauma Life Support. A time for reappraisal. *Anaesthesia* 1992;47:798-800.
- 8 Bennett JR, Bodenham AR, Berridge JC. Reply to letter by Lavery GG et al. *Anaesthesia* 1993;48:442-3.
- 9 Walsh DP, Lamert GR, Devoll J. The effectiveness of the advanced trauma life support system in a mass casualty situation by non trauma experienced physicians. *J Emerg Med* 1989;7:175-80.

THE FACULTY OF ACCIDENT AND EMERGENCY MEDICINE SPECIALTY EXAMINATION

The Specialty Examination of the Faculty of Accident and
Emergency Medicine will be held on the following dates

21/22 May 1997 at the Royal College of Surgeons of
Edinburgh Closing date - 26 March 1997
Fee - £550

12/13 November 1997 at the Royal College of Surgeons
of England Closing date - 17 September 1997
Fee - £600

Regulations and application forms are available from:

The Secretariat
Intercollegiate Specialty Boards
3 Hill Square
Edinburgh
EH8 9DR
Tel: 0131 662 9222
Facs: 0131 662 9444

the study highlighted distal radial fractures (eight in the study), particularly undisplaced fractures, as an area for particular vigilance. Two toddler's⁷ fractures were identified and patients in this group should be followed up by repeat x ray at two weeks if still not weight bearing. Two troublesome ankle injuries were resolved by therapeutic arthroscopies following MRI demonstration of osteochondral talar dome fractures.

Fourteen fractures were picked up on imaging modes other than plain x ray. The superiority of other imaging techniques has previously been shown in the case of bone scanning for scaphoid fracture,⁸ and a role for magnetic resonance imaging⁹ and bone scanning¹⁰ has been advocated in the A&E setting. These techniques are becoming increasingly available in A&E. In our study we found bone scan useful in scaphoid fractures and fractured neck of femur: CT in neck of femur and scaphoid fractures, and MRI in ankle fractures.

CONCLUSIONS

Negative initial plain x rays are not always conclusive evidence of the absence of a fracture in A&E trauma patients. Persistent organised review by experienced A&E staff with direct involvement of the radiology department in the face of continuing clinical suspicion will help to detect these occult fractures. Other imaging

techniques should be considered in consultation with the radiologists. The responsibility for patients in this group rests with the A&E department until a fracture is positively identified. Review clinics run by A&E senior staff, a follow up protocol for junior A&E staff, and clinicoradiological meetings and audit will help to reduce disability in these patients and reduce the likelihood of litigation.

- 1 Tiel-van Buul MM, van Beek EJ, Broekhuizen AH, Nooitgedacht EA, Davids PH, Baker AJ. Diagnosing scaphoid fractures: radiographs cannot be used as a gold standard. *Injury* 1992;23:77-9.
- 2 Evans PD, Wilson C, Lyons K. Comparison of MRI with bone scanning for suspected hip fracture in elderly patients. *J Bone Joint Surg Br* 1994;76:158-9.
- 3 Laasonen EM, Kivioja A. Delayed diagnosis of extremity injuries in patients with multiple injuries. *J Trauma* 1991;31:257-60.
- 4 Born CT, Ross SE, Iannacone WM, Schwab CW, De Long WG. Delayed identification of skeletal injury in multisystem trauma: the "missed" fracture. *J Trauma* 1989;29:1643-6.
- 5 Moore MN. Orthopaedic pitfalls in emergency medicine. *South Med J* 1988;81:371-8.
- 6 Thomas HG, Mason AC, Smith RM, Ferguson CM. Value of radiograph audit in an accident and emergency department. *Injury* 1992;23:47-50.
- 7 Shrivast BP, Harrop SN, Kane TP. Toddler's fracture. *J Accid Emerg Med* 1996;13:59-61.
- 8 Murphy D, Eisenhauer M. The utility of a bone scan in the diagnosis of clinical scaphoid fracture. *J Emerg Med* 1994;12:709-12.
- 9 Feldman F, Staron R, Zwass A, Rubin S, Haramati N. MR imaging; its role in detecting occult fractures. *Skel Radiol* 1994;23:439-44.
- 10 Heinrich SD, Gallagher D, Harris M, Nadell JM. Undiagnosed fractures in severely injured children and young adults. *J Bone Joint Surg Am* 1994;76:561-74.

Referees for the Journal of Accident & Emergency Medicine

All papers submitted for publication in the *Journal of Accident & Emergency Medicine* undergo peer review. As a result of the continuing rise in the number of papers received the *Journal* seeks additional referees.

This is an interesting and stimulating activity. The Editorial Office ensures that the workload for referees is not onerous and guidelines are provided to allow a structured critique of each paper. Referees are expected to return comments within three weeks of receipt of the manuscript.

Please contact the Editor, *Journal of Accident & Emergency Medicine* at BMA House, Tavistock Square, London WC1H 9JR, telephone 0171-383-6795, fax. 0171-383-6668, stating your present appointment and any areas of special expertise. Reviewers are particularly welcome from other specialties with an interest in *Emergency Medicine* and from outside the U.K.

We could show that we needed an increase in our nursing establishment, the main pressure being on tasks not requiring qualified nurses. This released qualified staff for skilled procedures and teaching.

Lastly, in the process of establishing consensus lists of care needed by each patient with a given presenting complaint and clinical condition, we discovered a number of poor or inconsistent clinical practices which opened discussion on why we do things the way we do. We arrived at consensus lists that detailed what should ideally be done—and what should not be done. These lists now form agreed management protocols or “standards of care” and are incorporated into the departmental handbook given to new A&E SHOs. For nursing staff, those consensus lists have served as a basis for attempting to set standards throughout the department.

The workload management system we described is flexible enough to be used by other departments as it can be tailored to suit very different local peculiarities. Before embarking on this, it is vital to ensure the commitment of all staff at all levels. The system will probably show that some well loved practices are inefficient; everyone must be prepared to let go of the old and explore possibilities of change.

We thank Pat Harwood, Ros Plampin, and Wendy Martin for their efforts in developing the system.

- 1 Department of Health. *Working for patients* (CM 555). London: HMSO, 1989:15.
- 2 Tandberg D, Qualls C. Time series forecasts of Emergency Department patient volume, length of stay and acuity. *Ann Emerg Med* 1994;23:299–306.
- 3 Graff LG, Wolf S, Dinwoodie R, Buono D, Mucci D. Emergency physician workload: a time study. *Ann Emerg Med* 1993;22:1156–63.
- 4 O'Brian-Pallas L, Cockerill R, Leatt P. Different systems, different costs? An examination of the comparability of workload measurement systems. *J Nursing Admin* 1992; 22:17–22.

ADVANCED LIFE SUPPORT GROUP

Major Incident Medical Management and Support Courses: to be held in various centres throughout the UK in 1997. This is a three day course in “life support style” designed to train health service personnel to provide an effective response at a major incident.

Fee £300.00

Advanced Paediatric Life Support Courses: to be held in various centres throughout the UK in 1997. This is a three day course designed to provide training which will enable doctors and nurses to deal efficiently with all paediatric emergencies. The course is modular and has sections on paediatric resuscitation, serious illness and serious injury.

Fee varies according to centre. Range £300.00 - £350.00.

Inquiries for both courses to:
 Jenny Antrobus
 Advanced Life Support Group
 Second Floor, The Dock Office,
 Trafford Rd., Salford Quays,
 Manchester M5 2XB
 Tel 0161 877 1999
 Fax 0161 877 1666

treatment. There were, however, anecdotal reports from A&E team leaders of some clinicians from the intensive care unit (often juniors) attempting to use a low initial admission GCS as a way of triaging patients away from receiving ICU care. As Dr Cameron points out, such an occurrence would obviously be a powerful confounding factor to our study. In reality joint discussion between A&E, ICU, and senior medical staff in such situations usually resulted in the patient being transferred to the most appropriate facility.

However, we would accept that a possible hidden confounder is that in such patients being admitted to an ICU, clinicians may decide that aggressive therapy might be inappropriate, as outcome is perceived to be poor. As suggested, it is important therefore to develop joint guidelines with the ICU to minimise the potential for disagreement in early postresuscitation care in order that all patients are given the best possible opportunity for survival.

T B HASSAN
F G HICKEY
S GOODACRE
G G BODIWALA
*Accident and Emergency Department,
Leicester Royal Infirmary*

BOOK REVIEW

Self-assessment in Accident and Emergency Medicine. By Derek Burke, Ian Greaves, Philip Hormbrey. (Pp 220; £15.99.) Oxford: Butterworth Heinemann, 1996. ISBN 0 7506 2215 6

There is no doubt that within the very near future, increasing numbers of hopeful junior doctors in the United Kingdom will be taking exams in A&E. Mindful of this, the authors of this paperback have produced 200 pages to help cater for their needs. The book is very good. It is perhaps a tribute to its content that the greatest criticism relates to its presentation. Throughout, the text is unjustified, which makes it slightly unsettling to read and creates an unnecessarily scruffy appearance.

The first half of the book is devoted to multiple choice questions (MCQs) with accompanying discussion. A wide range of topics is covered in the questions, which are followed by relevant and informative explanation. It is

no surprise that some of the answers are controversial. Collect together several experts (or junior doctors with large textbooks, which amounts to the same thing), present them with a few MCQs and there will be predictable argument about which are the correct answers. This applies to even the most supposedly carefully worked out questions, as generations of frustrated physicians studying the MRCP part 1 past papers will testify. Criticism of the content of this book on these grounds is therefore perhaps a little unfair. However, it seems rather a shame that within the first question at least one answer is controversial and appears to be at odds with its associated discussion.

The remainder of the book comprises questions on case histories, data interpretation, clinical pictures, and x rays. Once again, a variety of subjects is addressed in a lively and stimulating fashion, thus maximising the chance of maintaining the interest of overworked A&E trainees. Indeed, the whole book is written in such a way that it can be usefully picked up for a few minutes at a time. It can be strongly recommended as a study aid for postgraduate A&E exams.

JONATHAN WYATT
Edinburgh

MID-TRENT PAEDIATRIC TRAUMA CONFERENCE

June 2-3 1997

Venue:

**The Village Hotel
Chilwell
Nottingham**

A two day conference addressing the challenges, controversies and future of paediatric trauma management featuring local, national and international speakers.

Booking details are available from:

**Ricci Capaldo
Accident and Emergency Department
Queen's Medical Centre
Nottingham NG7 2UH
Telephone 0115 970 9153**

Organisers

**Lynn Williams FRCS Susie Hewitt FRCS Jean Nixon RGN Jackie Koogh RGN
Accident and Emergency Departments
Queen's Medical Centre and Derbyshire Royal Infirmary**