Management of major trauma

EDITOR,—With major trauma comprising 1 per 1000 emergency cases in Britain there is limited opportunity to develop expertise in the management of this condition. Many of these patients arrive at hospital during unsocialable hours when accident and emergency (A&E) departments are often staffed by inexperienced junior doctors. In this situation initial resuscitation should be transferred to the intensive care unit promptly. Unfortunately many district general hospitals are unable to provide an appropriate service from these specialties. The problem is compounded by the general apathy to trauma shown by many senior surgeons. While we would agree with Leaman that all hospitals involved in trauma care should submit data to MTOS, we would not expect the results to be encouraging. Recent analysis of data submitted both to MTOS and to the Scottish Trauma Audit Group showed mediocre results, with delays in treatment despite senior staff involvement in initial resuscitation.

It is obvious that Leaman is not a practitioner of aeromedical helicopter transport; however, in his local region 22% of the County Ambulance missions over the last five years involved interhospital transfers. We suggest this service should continue to be used for transfers involving significant distances, where severe traffic congestion on motorway networks may result in prolonged journeys by land ambulances and for those patients whose clinical condition benefits from the method of transport for example spinal injuries. The Glasgow Clinical Shock Study Group provides the gold standard for interhospital transportation; however, as they point out, the development of an integrated transport system involving experienced doctors is unlikely to become a realistic option in Britain due to the financial implications involved between different hospital Trusts.

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Management of severe epilepsy with lignocaine

EDITOR,—We report a patient with status epilepticus following generalised tonic status epilepticus, who was successfully treated with intravenous lignocaine after treatment with diazepam plus phenytoin. A 68 year-old man was admitted with a tonic generalised convulsion. He had a 40 year history of heavy alcohol intake and recurrent minor head traumas, although computerised tomography of the head showed nothing abnormal. Tonic generalised convulsions, each lasting for about one minute, occurred repeatedly. The interval between attacks was about 15 minutes, during which he was unresponsive to verbal stimuli. Diazepam 10 mg was given intravenously with no effect. Phenytoin 750 mg intravenously was then given and the level of consciousness improved within two hours. However, a right tonic hemiconvulsion persisted, although the interval was prolonged to three to four hours on the day after admission. Despite of the additional administration of diazepam and phenytoin intravenously over the following 24 hours, the right tonic hemiconvulsion recurred. An intravenous bolus of 100 mg lignocaine was therefore given during the attack, and the convulsion completely disappeared within about 30 seconds. The patient was then given a continuous intravenous infusion of lignocaine, 1 mg/min, and oral phenytoin, 300 mg/day. Status epilepticus did not recur. On day 10, the lignocaine was discontinued and convulsions did not recur thereafter. The electroencephalogram on day 12 revealed no epileptic findings.

Currently, lignocaine is considered as the third line agent in the treatment of status epilepticus when first line agents, such as diazepam and phenytoin, and second line agents, such as barbiturates, fail to control seizures.1 However, the best treatment of status epilepticus has yet not been established, although barbiturates, carbamazepine, and phenytoin are recommended.2 We gave lignocaine because of the interest in the brain and the first line agents and the possibility of respiratory suppression by second line agents. A search of the literature revealed one case report of focal status epilepticus treated with lignocaine.3 This report emphasised that lignocaine does not cause sedation and rarely depresses the cardiovascular or respiratory systems when given in therapeutic dosage. The obvious effectiveness of lignocaine in our case suggests that this is a drug of choice in the treatment of status epilepticus with focal seizures.

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Decision support for telephone advice

EDITOR,—We read with interest the paper by Strine et al. Since 1993 we have been researching telephone advice in A&E and general practice and have developed approaches to standardising patient assessment and advice. This includes piloting a telephone consultation skills training package and a computer based decision support system.1,2 Our findings, based on an analysis of 340 calls to an A&E department, concur with those of Strine et al. Our A&E, 21% to attend their GP, and 31% given home care advice. We found similar support from the nursing staff using the system. We also found that 53% of people were aware that the nurse was using a computer, and the majority (75%) believed it to be a good idea to use computers to provide clinical care.

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