Obstacles to research in A&E

EDITOR,—Harnden et al point out that research in A&E lags behind that of other specialties. They highlight the need for a sufficiently large group of A&E doctors with the skills needed to plan and execute top-quality research; such research will not be stimulated without adequate funding. The specialty needs to lobby for topics in emergency medicine to be included in the priority areas for NHS research and development. Without such funding it is probable that only ad hoc studies without rigorous design will be undertaken.

An American study showed that finding time and funding, administrative obligations, and pressures to do clinical work were the most important obstacles to research productivity.1 A survey has recently been undertaken within the West Midlands to establish what trainees considered to be the main obstacles to undertaking research. Thirteen trainees attending a regional training afternoon were asked to complete a questionnaire anonymously. They were asked “What do you see as the main obstacles to research in your present A&E post” and were asked to score nine areas from 1 to 5, 1 being an important obstacle and 5 being not seen as an obstacle. They were also asked to specify any other obstacles which were not included in the original list. The results are summarised in table 1. No additional aspects were volunteered apart from the nine areas we had provided. Only three individuals (23%) had published a paper or presented a paper relating to a trial or questionnaire study in the last two years. The use of protected time for research was deemed important, although it could be argued that this result suggests the need for better time management. The responses suggest a need to include more teaching in research methodology. Most of the problems would, in our opinion, be improved by the research support provided by access to an academic department. It is reassuring to see that trainees are interested in research and the lack of compulsion is not preventing their participation.

We reviewed articles published in 1996 in the Journal of Accident and Emergency Medicine. Table 1 shows the number of articles in each subject area classified under the categories of research in their titles and abstracts. The table shows that in 1996 Accident and Emergency Medicine had 11 papers reporting research.


The groin cannula: effective pain relief for fractured neck of femur

EDITOR,—In 1995 the Audit Commission published “United they stand”, on coordinating care for medically qualified accident and emergency doctors. Although the document emphasises that the total package of care rather than any one single factor influences outcome, the East Anglian Audit and the Hastings Accident and Emergency Audit report did not give special mention. The former suggests that early mobilisation reduces both mortality and length of stay, and the latter encourages the use of nerve blocks for immediate analgesia.

Finlayson and Underhill found femoral nerve block to be effective in cases of both extracapsular and intracapsular fracture. The safety and effectiveness of large volume femoral nerve block in cases of extracapsular femoral neck fractures have recently been confirmed by Haddad and Williams in a randomised controlled trial. Single injections were carried out in A&E using a volume of 0.3 ml/kg of 0.25% bupivacaine. The volume is large enough to spread proximally and block the adjacent obturator nerve and lateral cutaneous nerve of thigh, producing a so called 3-in-1 or triple nerve block.

The duration of statistically significant reduction in pain in the Haddad and Williams study was between two and eight hours. In order to maintain this efficient means of pain relief, which lacks the troublesome side effects of opioid, it is necessary to make use of continuous infusion or intermittent top ups.

One of us (JM) has evaluated the ease of placement of an 18G venous cannula (Venflon, Viggo, Sweden) in the femoral nerve sheath to establish and maintain (by intermittent top up) triple nerve block in 42 cases of fractured neck of femur. Percutaneous cannula placement is guided by palpation of the femoral artery and the patients’ reporting of paraesthesia in the distribution of the femoral nerve.

The results are shown in table 1. No cases of vascular puncture were encountered. Initial doses were usually 0.5% bupivacaine, 0.3 ml/kg, and intermittent top ups of 20 ml of 0.25% bupivacaine were given by orthopaedic SHOs twice daily at 10.00 and 22.00.

Table 1

<table>
<thead>
<tr>
<th>Analysis</th>
<th>from triple nerve block</th>
<th>Effective</th>
<th>Ineffective</th>
<th>% Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractured NOF</td>
<td></td>
<td>31</td>
<td>11</td>
<td>74</td>
</tr>
</tbody>
</table>

In conclusion, local anaesthetic nerve block can be established easily in the A&E department using a percutaneous blind technique with an 18G venous cannula. Intermittent top ups with local anaesthetic may then be carried out by orthopaedic surgeons, thus maintaining this very efficient method of analgesia. Use of a nerve stimulator to guide placement of the cannula and improve the rate of success is now being evaluated.

JOHN MACKENZIE
Department of Anaesthetics, Royal Berkshire Hospital, Reading

RICK PULLINGER
Department of Accident and Emergency Medicine, John Radcliffe Hospital, Oxford


Emergency medicine training in Australia

EDITOR,—A period of emergency medicine training in Australia for United Kingdom trainees was endorsed by Ryan and Gaudry in their recent article.1 The two main benefits for