UK trainees are the greater number of emergency medicine trained consultants in each department and the referral practices of general practitioners in Australia.

The first benefit allows increased shop floor supervision and training from experienced mentors, thus enabling professional development to proceed apace with the trainee's requirements.

The second benefit is the clinical exposure to acutely unwell medical and surgical patients as emergency medicine, hence to acutely unwell medical and surgical patients in emergency departments in Australia. It is standard practice for all unwell patients seen by a GP to be referred to the emergency department for assessment and treatment. This practice is reviewed by senior staff and if required are referred to an inpatient specialty team for ongoing management. Hence trainees in Australia will be exposed to a wide variety of clinical cases throughout their training.

Current developments in the United Kingdom include an increase in the number of emergency medicine trained consultants in hospital A&E departments, thus only improving patient care but also the training of junior doctors. The future of training in this regard would thus seem assured.

Of more concern, however, is the increase in the development of emergency referral units, whereby GPs can bypass the A&E department and refer directly to an inpatient team. These are supported on the grounds of "taking the strain off A&E". While this may decrease the number of patients seen in A&E, the case has yet to be proved that it improves either the quality or the timing of patient care. If this practice is allowed to develop unchecked then the implications for training in the United Kingdom are enormous, as trainees will see less and less non-traumatic illness during their A&E department training. Once again hospital A&E departments will have to call themselves "casualties", as trauma will be the only illness treated therein. Will we see a time when UK trainees have to go to Australia to see any acute general surgery or acute general medicine diagnosed and managed in an A&E department?

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Unusual complication of interhospital transfer

Editor,—We have recently seen an unusual complication of interhospital transfer. A six year old girl fell off a kerb onto her left elbow and attended the local accident department the same day. She was seen and had x rays of the elbow. The films were marked with a red dot as a warning by the radiographer. No abnormality was noted by the A&E junior doctor and the patient was discharged with instructions to report to the A&E department of their home town (Basingstoke) if the elbow did not improve. The unreported x rays were given to the child's mother, but no notes.

The mother and daughter attended our department some three and a half months later as a patient in the clinic. Examination showed limitation of flexion, and pain on supination of the left elbow. Further radiographs were taken, which our junior doctor felt were normal. In view of the continued pain the child was asked to attend our review clinic, and at this stage the diagnosis of a dislocated radial head was made.

Review of the x ray films showed that this was suggested on the originals (as seen by the radiographer) (fig 1) and was obvious on our second set of films. The orthopaedic team felt her injury should be managed conservatively, but if her loss of function increased then operative intervention would be needed.

Unilateral traumatic radial head dislocation is an uncommon injury commonly missed by inexperienced junior doctors in accident departments. Early recognition and closed reduction is the recommended management.

This case illustrates the problems of a poorly documented (no notes with patient) and badly instructed transfer. Even in minor injuries, when the care of the patient is being transferred to another hospital it is essential that they should have a copy of the notes and the x rays with them, as well as being given precise instructions on their attendance. If practical the hospital should be contacted and a definite arrangement made. These simple rules would have avoided the delay and potential complications for this patient, although a stoical parent is an unusual hazard in patient transfer!


Telephone survey of Difterax use at school leaving age

Editor,—In 1994 the Department of Health announced the introduction of low dose diphtheria and tetanus vaccine (Td) (40 IU tetanus toxoid—4 IU diphtheria toxoid) as a replacement for the routine tetanus only booster at school leaving age.1 This followed concerns about the long term immunogenicity of diphtheria in the former USSR.2 The diphtheria epidemic is due to waning immunity in the population (antibody to diphtheria declining with age), leaving people vulnerable to infection. Hence Td should be given to children age 10 and over who require antitetanus prophylaxis and have not yet received Td booster. If subjects who are 10 and over were given a tetanus only booster they could at a later date be given either a monovalent diphtheria vaccine,3 which is low dose adult vaccine, or 0.1 ml of Evans paediatric diphtheria vaccine.4 However, giving a child over the age of 10 years a tetanus only booster means that a diphtheria only booster has to be obtained to supplement it and the child is subject to another injection, which could be avoided.

Paediatric diphtheria and tetanus vaccine (DT) (40 IU tetanus toxoid—30 IU diphtheria toxoid) contains a higher concentration of diphtheria toxoid which can cause adverse reactions; hence Td is suggested above the age of 10 years and the paediatric diphtheria—tetanus vaccine should not be given. Also if Td is repeated within a span of one month it can cause an adverse reaction. This requires proper communication between an accident and emergency (A&E) department which gives Td and both the parents and the family doctor.

During the period December 1994 to May 1996, 25 A&E departments were assessed randomly and down the country with three sets of questions which were put to both medical and nursing staff. Questions were aimed to find out whether departments stocked Td and under what circumstances it was used. The following questions were asked:

(a) If a 15 year old child presented to your department with a wound or burn and he had not yet received his school leaving tetanus only booster would he be given a tetanus booster?
(b) If yes, would he be given a tetanus only booster or the combined low dose diphtheria and tetanus vaccine?
(c) Does your department stock the low dose diphtheria and tetanus vaccine (Td)?

The results are shown in table 1.

Table 1 Results of telephone survey of Difterax use

<table>
<thead>
<tr>
<th>Question</th>
<th>Nurses</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 &amp; 2</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Given Td booster</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Referrer to GP</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Difterax in stock</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Yes</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Don't know</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Access to British A&E departments over the telephone was found to be difficult; however, of the 25 departments surveyed only 16% stocked Td and half of them (8%) failed to use it. This suggests that half the departments stocking Difterax failed to recognise the indications for its use. To date, communication concerning Difterax has been mainly in the CMO's updates and the British National Formulary. These do not appear to have been...