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Faculty of Accident and Emergency Medicine

Consultant appointments, January–April 1997

Mr K A Bizos	Stoke Mandeville Hospital, Aylesbury
Mr M J Stuart	North Manchester Healthcare
Mr S Bhattacharyya	Burnley Healthcare
Mr H Dardouri	Blackburn/Ribble Health
Ms J Nancarrow	Blackburn/Ribble Health
Mr J McKeever	Greenwich Healthcare
Mr M Morris	Warwick Hospital

Consultant appointments April–September 1997

Ms M Dudek	Royal Berkshire Hospital
Ms M Grocott	Worthing Hospital
Mr A I Jones	North Tyneside Healthcare
Mr A MacNamara	Birmingham Heartlands
Mr D McCreadie	New Cross Hospital, Wolverhampton
Mr S J McGovern	Craigavon Area Hospital
Mr A L Pinto	Wigan and Leigh Health
Mr A Soorma	MidKent Healthcare Trust
Ms C Taylor	Queen Mary's Sidcup
Mr M Zahie	New Cross Hospital, Wolverhampton

over 5000 11-14 year old Newcastle schoolchildren indicated that boys were 7.5 times more likely than girls to play football at least weekly (Towner EML, unpublished data). While 98% of the football injuries affected males, in those aged 16 and below there were 33 in males and two in females. The association between all types of skiing and thumb injury is well documented.[13] There is no dry ski slope in Newcastle, so this may be more significant in other locations.

Patients with a poor outcome (moderate pain and/or severe problems) were older than the average in this study: median 24 years, range 13 to 42. The similarity between levels of impairment at discharge and at subsequent follow up has a clinical implication: patients with poor function after a hand injury should not be discharged from review in the expectation that they will improve with time.

STRATEGIES FOR INJURY PREVENTION

Further collaborative work is in progress to disseminate these results to local injury prevention agencies. We aim to raise local awareness in sports teachers, particularly in secondary schools; this was the setting for an effective campaign to reduce dental injuries in rugby players in New Zealand.[14] Secondary schools in Newcastle[15 16] and in general[17] appear to be a common location for both sports and non-sports injury. The pupils are mainly supervised during school activities; teachers and parents are in a position to educate children, influence the way sport is played, and enforce environmental modifications such as the introduction of protective equipment. By raising awareness of our findings we hope to reduce hand injuries and help sports workers ensure that the right people are playing the right sport in the right environment.

CONCLUSIONS

Sports injuries to the hand requiring treatment in the A&E department may result in significant short term and longer term functional impairment. Prevention of these injuries should be addressed locally by targeting secondary schools and specific sports, particularly football, netball, and basketball.

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JOURNAL SCAN

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This scan coordinated by R Bailey

The behavioural response to whiplash injury

Gargan M, Bannister G, Main C, Hollis S
Journal of Bone and Joint Surgery 1997;97-B:523-6

Aims—To investigate pre-existing and developing behaviour disorders in patients with whiplash injury.

Design—An observational study over two years of 50 patients with whiplash injury, measuring clinical symptoms and using the general health questionnaire (GHQ) as a measure of psychological symptomatology. Patients were reviewed at one week, three months, and two years after injury, and were categorised into those whose symptoms were absent, a "nuisance," "intrusive," or "disabling." Groups with no/nuisance symptoms were compared with those with intrusive/disabling symptoms.

Results—At three months (and two years) 15 (19) patients were asymptomatic, 20 (15) had nuisance symptoms, 15 (17) intrusive symptoms, and 2 (1) disabling symptoms. There were no significant differences between groups in the level of psychological symptoms within the first week of the injury. At three months and at two years there were highly significant differences between those who were asymptomatic/had nuisance symptoms and those with intrusive/disabling symptoms. At three months, the range of neck movements in both groups was significantly different. Using the range of movement and GHQ at three months it was possible to predict with 82% accuracy the outcome at two years.

Conclusions—The authors concluded that pre-existing psychological symptoms were similar in patients who made a good recovery and those that had prolonged recovery. They state that the symptoms after whiplash injury are physical and psychological and that the psychological response develops after the injury (between one week and three months). The best time to target any treatment for this injury is probably within the first three months.

Critique—A well structured investigation into a common problem. No reason is given for analysing the results by aggregating the initial four study groups into two, but this was most likely to have been due to small numbers in the "disabling" group. The GHQ is a well tested measure and the statistical tests were appropriate. There was a small number of patients in each group with abnormal GHQ scores at one week and these were more likely to be in the group with more prolonged symptoms. The study only enrolled 50 patients and may not have had enough power to prove significance. However, the differences at three months were highly significant so any pre-existing difference in psychological wellbeing could only play a very minor (if any) part in the overall psychological outcome.

The assertion that the study could predict outcome at two years seems to be true for those with good outcomes (94% accuracy) but it was poor at predicting those with poor outcomes (56% accuracy). The study rightly highlights the importance of the psychological impact of injury and indicates that physical symptoms precede the psychological response.

Patients with suspected myocardial infarction presenting with ST segment depression

Lee HS, Brooks N, Jennings K
Heart 1997;77:493-4

ST segment depression of more than 3 mm is highly specific for the diagnosis of acute myocardial infarction. Patients tend to be older, with previous infarcts and severe coronary artery disease. The mortality is high and thrombolysis appears not to improve mortality rates (GISSl and ISSIS-2); only one study (LATE) has shown benefit. Aspirin improves survival. The authors conclude that in this group of patients treatment should be aspirin, buccal nitrate, and a repeat ECG at 15 minutes. In patients with persisting or worsening ST depression, urgent angioplasty or coronary artery bypass may be beneficial. However, they still advise that "if such an interventional approach is not feasible, administration of a rapidly acting thrombolytic agent should be considered."

Further reading: Langer A, Goodman SG, Topol EJ, *et al.* Late assessment of thrombolytic efficacy (LATE) study: prognosis in patient with non Q-wave myocardial infarction. J Am Coll Cardiol 1996;27:1327-30.

Minor head injury

Beatie TF
Archives of Disease in Childhood 1997;77: 82-5

This review article highlights the problem of minor head injury in children. The importance of the mechanism of head injury is emphasised along with a history of loss of consciousness as indicators of possible more serious injury. The difficulties in assessing young children are discussed, where exact information about periods of unconsciousness is hard to elicit. In this group pallor, periods of apnoea, and failure to cry immediately after the injury are important findings. It is suggested that a skull *x* ray is indicated in patients with significant mechanisms of injury, a history of any loss of consciousness, clinical base of skull fracture, and age under one year (problems with assessment and possible non-accidental injury in this group). The child with a skull fracture should be admitted. There is controversy whether all children with skull fractures should have computerised tomography.

Children with no fracture and no neurological signs or major symptoms can be allowed home unless there are concerns regarding the social environment, difficulty in returning to hospital, or if there are concerns about possible non-accidental injury

Follow up arrangements are often inadequate as following even a minor head injury 7% of children may develop behavioural problems.

Imported malaria in children in the UK

Brabin BJ, Ganley Y
Archives of Disease in Childhood 1997;77:76-81

In the United Kingdom during 1995 there were 306 cases of malaria diagnosed in children (less than 15 years of age). This may become more common with increasing travel. Children are at particular risk as diagnosis can be difficult and symptoms may progress rapidly. They may also have problems with prophylaxis.

The article discusses the incidence, diagnosis, treatment, and prophylaxis of the disease, emphasising that any child with a fever who has travelled to a malaria area in the previous 12 months should have appropriate blood films

examined. Early diagnosis and treatment of malaria will prevent serious sequelae or death.

Partial lacerations of the flexor tendons in children—primary repair versus conservative treatment
Stahl S, Kaufman T, Bialik V
Journal of Hand Surgery
1997;**22B**:377
The authors retrospectively compared outcome in 17 partially lacerated (< 75% of cross sectional area (CSA) cut) flexor tendons in children treated by surgical repair with 19 tendons treated conservatively by early mobilisation. The optimal management of this injury is disputed, some recommending primary repair, others advocating early mobilisation without tenorrhaphy. In children flexor tendons heal more rapidly and injuries result in fewer complications than in adults, probably because of a better blood supply and greater capacity for remodelling. In the repair group, lacerations of < 25% CSA were only trimmed. Injures > 50% CSA were repaired. Active and conservative groups had similarly favourable results. No complications such as triggering or complete tendon rupture were found in either group. The authors advocate early mobilisation in children with partial division of the flexor tendon diagnosed clinically. Exploration should be undertaken in doubtful cases to exclude complete tendon division.

R BAILEY
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Abandoning empirical antibiotics for febrile children
Stamos JK, Shulman ST
Lancet 1997;350:84
This editorial commentary examines the care of children with a fever of unknown origin with no localising signs, advising that oral antibiotics should not be prescribed in such patients. There is an increase in multiresistant organisms and no evidence that this practice is effective. The authors emphasise the need for individual careful evaluation of such children. Ill looking and toxic children require admission to hospital for full investigation and consideration of intravenous antibiotics. Pneumococcal infection is now the most common cause of bacteraemia. Children who are not obviously unwell are unlikely to have a bacteraemia if their white blood count is less than 20×10^9/l. The authors advise a short period of observation of such children, either in A&E or on the ward.

Mallet deformity of the finger
Okafor B, Mbubaegbu C, Munshi I, Williams DJ
Journal of Bone and Joint Surgery (British edition) 1997;**79B**:544-7
This is a retrospective review of the long term outcome following conservative treatment of mallet finger. The mean time to review was five years after injury. Thirty five per cent of the patients had an intra-articular fracture. The mallet finger splint had been worn for a mean of 7.2 weeks; 48% had developed osteoarthritic changes, most common in those with fracture; 29% developed a swan neck deformity; 35% had a loss of more than 10 degrees of extension (average loss 8.3 degrees and average flexion arc 48.5 degrees). However, 90% of the patients were satisfied with the outcome, with no impairment reported by 68%. The authors conclude that the low rate of complications and high patient satisfaction support the continued use of the thermoplastic splint in mallet deformity of the finger.