Under these circumstances a chest x ray is mandatory to exclude a haemothorax. Late clotted haemothorax, once detected, requires an early thoracotomy for complete clearance and best long term results.

We thank Mrs Christina Hill and Mr Farid Khan in their help in preparing this paper.


Out of hospital cardiac arrest and associated injury

Andrew I Jones, M James Stuart, Alastair J Gray

Abstract
Three patients are described who sustained injuries around the time of a collapse that led to out of hospital cardiac arrest. In this group of patients the importance of taking a complete medical history and recording the circumstances of the syncopal episode cannot be overemphasised. If cardiac output is successfully restored the possibility of occult traumatic injury must be considered in high risk patients.


Keywords: cardiac arrest; resuscitation; occult trauma

In the immediate aftermath of a successfully resuscitated out of hospital cardiac arrest the presence of an injury may easily be overlooked. We present three cases which illustrate this point.

Case 1
A 65 year old male sustained a cardiac arrest in the street. Bystander basic life support was given immediately. The extended trained ambulance crew found him to be in ventricular fibrillation. Defibrillation restored sinus rhythm.

On arrival at the accident and emergency (A&E) department he was drowsy but responding to questions. He remained in sinus rhythm with a systolic blood pressure of 100 mm Hg. He appeared able to move only his shoulder girdles. Brusing to the forehead was noted.

Radiography of the neck showed advanced ankylosing spondylitis with a fracture-dislocation. He was stabilised on the intensive care unit but he died the following day.

Case 2
A 63 year old male sustained an out of hospital cardiac arrest. A nurse bystander gave basic life support. The attending extended trained ambulance crew found him to be in ventricular fibrillation, and sinus rhythm was rapidly restored by defibrillation. At this stage he was localising to pain and had a Glasgow coma score of 8. Examination at the A&E department showed bruising of his right temple. Radiography of his skull was normal but in view of his persisting reduced level of consciousness computed tomography was performed and showed frontal and temporal contusions. He was subsequently intubated and admitted to the neurosurgical unit. After 10 days he was discharged home.

Case 3
A 56 year old man suddenly collapsed in the street and was found to be in ventricular fibrillation by the attending ambulance crew. He was immediately cardioverted and cardiac output was restored.

On arrival in the A&E department he was agitated and combative. He was maintaining his own airway and his oxygen saturation was 99% while breathing high flow oxygen. He had
Ectopic pregnancy presenting with obturator nerve pain

Hassan Shaaban Ali

Abstract
A 27 year old woman had a three day history of pain in the cutaneous distribution of the left obturator nerve before she developed the classical picture of ectopic pregnancy with lower abdominal pain and vaginal bleeding. A left tubal pregnancy was subsequently confirmed by laparoscopy. Referred pain along the obturator nerve has been reported in other pelvic conditions, but has not previously been reported as a manifestation of ectopic pregnancy. Ectopic pregnancy may present with a very wide range of signs and symptoms and should be excluded in females of child bearing age with unexplained symptoms including pain anywhere from the shoulder down to the knee. (J Accid Emerg Med 1998;15:192–193)

Keywords: ectopic pregnancy; obturator nerve; referred pain

Case report
A 27 year old woman presented to the accident and emergency (A&E) department with a two day history of pain on the inner aspect of the left thigh, which later radiated to the left groin. There was no history of trauma. She had stopped taking the contraceptive pill one month before and her last menstrual period had been eight weeks ago.
the intensive care unit, and another from the
tomography scanner to the neuro-
surgeons in Nottingham.

The fire brigade came and informed us of a
fire in the basement under the department.
The department was full of smoke and we
could not work in it for several hours.
Several patients were sent directly to wards
and the ambulance service diverted patients
to other hospitals. We opened the outpatient
department and the day care unit and treated
casualties there. This makeshift plan was diffi-
cult to implement. A few hours later when the
fire was put out and the smoke dispersed, we
returned with our patients to an undamaged
department.

Before this experience we have had two fires
started deliberately by patients in the department—one in a toilet and one in a wait-
ing room. So the possibility of this, or indeed
any, emergency department being unable to
function for a period of time is always there.
Fire is the most likely cause but explosions,
building collapse, electrical failure, flooding,
and violent affrays are others. (Working in
over 20 hospitals over the last 35 years, AF-M
has seen all of these, but only the smoke from
this fire was serious enough to cause our
emergency department to be closed.)

We had no local plan in our hospital to deal
with this contingency. We do now have such
a plan and I am sure that other hospitals should
follow our example to avoid being caught out.

There are no national guidelines for hospi-
tals or accident and emergency departments
to close, but the ambulance service has
national guidelines for diverting all ambu-
lances to other hospitals in circumstances
such as these. This can easily be arranged
through your local ambulance service.

A mobile field hospital could in theory be
provided by the armed services. This requires
quite a fair sized space to set it up. Reliable
sources with experience of setting up these
hospitals have told us that this takes at least 48
hours. So this is not a “quick” option, but an
alternative if the emergency department is out
of action.

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Foreign body removal from children’s noses

EDITOR.—Nasal foreign bodies are a common
problem in children attending accident and
emergency departments and general practice
surgeries. The cooperation required is often
not forthcoming as most patients are under 5
years. Instrumentation requiring restraint,
sedation, or even general anaesthesia are
frequently necessary. This approach may be
avoided by using the positive pressure tech-
nique described below, which can be used by
the parent to quickly and safely remove a nasal
foreign body.1

A history is taken from the parent and child
to determine the nature of the foreign body and
which nostril is involved. If the child is
cooperative, the nares can be examined to
locate the foreign body but this is not always
possible if there is a clear indication of which nostril is involved.

Parents are instructed to sit the child on
their knee, with the nostril containing the for-

dign body closest to the parent. The parent
should then close the “patent” nostril using a
ginger and tell the child that they are going
to give them “a great big kiss”. Parents should
then seal their lips around the child’s and
deliver a short sharp puff of air. The foreign
body is usually extruded with one puff. It is
worth holding a paper tissue close by as the
foreign body is usually well covered with
toxic mucus. If this is unsuccessful several
attempts can be made without any harm. Each
additional “puff” may dislodge the foreign
body a little further.

The author devised this technique in over
20 cases with no failures or complications.
Various objects including beads, peas, pieces
of bread, and even a rabbit dropping have been
removed successfully. The time from
insertion of the foreign body to removal by the
technique does not appear to be a factor.

Despite the simplicity of this technique it
seems little used. It is easily taught to parents
and can be undertaken in any setting. Use of
restraints, anaesthesia, and instrumentation in
frightened and distressed children can be avoided.

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1 Backlin SA. Positive pressure technique for nasal
2 Werman HA. Removal of foreign bodies of the
nose. Emerg Med Clin North Am 1987;May:
253–63.
3 Cohen HA, Goldberg E, Theore Z. Removal of
(Phila) 1993;32:192.

Alcohol intoxication

EDITOR.—I read with great interest the recent
letters by Tovey et al2 and Denning3 regarding
the alcohol content of some proprietary
medicated products and commercially
available mouthwashes. Previously I was able
to highlight the potential danger to children of
perfumed body sprays,4 which commonly have
an alcohol content of between 70–80%.
A child attended the accident and emergency
department having ingested the contents of
a “tangerine dream” perfumed body spray.
She was admitted, but fortunately came to
no harm. The presentation of this brand of
perfumes was extremely suggestive of a soft
drink. No warning was displayed on the
containers, which could easily be opened by a
child. This article was picked up by several
newspapers and a parenting magazine. I
subsequently noticed that the company selling
these products had withdrawn them from their
shelves. The enormous power of the media
should be harnessed whenever possible in
these and similar areas to protect the most
vulnerable in society.

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2 Tovey C, Rana PSJB, Anderson DJ. Alcohol
1998;15:70.
4 Moore D, Gronow R, McCabe M. Small
children may consume perfumed body spray
after misinterpreting it for soft drinks. BMJ 1996;
313:757.

Fitness to drive

EDITOR.—Each year there are more than
15 million visits to UK accident and
emergency (A&E) departments.1 Many sus-
tain injuries, suffer from medical conditions,
or have had drugs administered to them that
temporarily impair the patient’s ability to
drive safely. Yet it is rare to hear discussion of
this issue with the patient. A small prospec-
tive audit of 21 patients of driving age who
were discharged from the department after
the application of a limb plaster failed to
demonstrate any written advice as to whether
they should drive or not.

It is clear that a doctor has a legal duty to
warn those patients whose driving may be
impaired not to do so and to record this in the
notes.2 Patients who fail to take the advice of
the doctor will probably invalidate their
insurance.3 The responsibility for the provi-
sion of advice for this patient group lies with
each A&E department. “Suitability to drive”
is now covered in the senior house officer
teaching programme.

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1 Audit Commission. By accident or design. Lon-
2 Montague A. Legal problems in emergency medi-
3 Guidelines GEB, Hammerton A. Doctor, when
can I drive? A medical and legal view of the
implications of advice on driving after injury or opera-

Corrections

Out of hospital cardiac arrest and associ-
ated injury by Andrew J Jones, M James
Stuart, Alastair J Gray (J Accid Emerg Med
1998;15:191–2). We regret that because of
a production problem the affiliations of the
authors of this paper were omitted. They are as follows:

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* * *

Implementing the Ottawa ankle rules in an
Asian accident and emergency medical
department. What potential for saving? (J
that there was a spelling error in the first
author’s name: this should have been
Rainer rather than Stainer.