**Traumatic pericardial tamponade**

**EDITOR,—**We agree with Crawford et al.1 that it is difficult to make an early diagnosis of cardiac tamponade and even more difficult to diagnose penetrating cardiac injury in the haemodynamically stable patient without tamponade. Once tamponade has developed immediate intervention is critical. The role of rapid ultrasound and cross sectional echocardiography needs further clarification in these situations.

In several American trauma centres ultrasound examinations looking for haemopericardium and the more informative cross sectional echocardiography have been found to be very useful for the early diagnosis of penetrating cardiac injuries in haemodynamically stable patients, provided that are performed diately in the resuscitation room and performed and interpreted by trained technics, radiologists, trauma surgeons, or emergency physicians. In a study by Rozyczki et al2 of 247 patients who had ultrasound carried out by trauma surgeons, the sensitivity, specificity, and accuracy was 100%.1 Similarly, in a report by Ma et al3 of 245 patients who had ultrasound carried out by emergency physicians, the sensitivity, specificity, and accuracy were 100%, 99%, and 99% respectively.1 Freshman and his colleagues did not show false negatives in a cross sectional echocardiographic examination of 52 patients in whom no pericardial effusion was found, contrary to the statement by Crawford et al.1 However, a recent prospective study of 105 patients by Meyer et al4 showed that false negatives were a problem only in patients with a haemothorax, as cross sectional echocardiography missed four significant injuries. Otherwise the sensitivity, specificity, and accuracy of this investigation in those without haemothorax is at least as high as that of subxiphoid pericardiocentesis (100%, 89%, and 90% respectively).

The paper highlights the difficulties we face in the management of patients with traumatic haemopericardium in hospitals without cardiothoracic services on site. The matter is further complicated where there is no reliable 24 hour ultrasound service. In Glasgow, two haemodynamically stable patients decompensated rapidly, one requiring an emergency thoracotomy in the ward and the other in the resuscitation room. Both survived, but the outcome may have been different in other units. We suggest that another lesson to be learned from their experiences is to consider the option of rapid ultrasound or cross sectional echocardiography as early as possible when cardiac injury is suspected.


**SHOs’ interpretation of x rays**

**EDITOR,—**The article by McLauchlan et al on x ray interpretation by A&E SHOs5 is both unscientific and unfair on our junior colleagues. The paper,5 which shows that SHOs interpret up to 100% of abnormal x rays, is not a new finding. It has been known for years that radiologists interpret up to 100% of abnormal x rays (and even more up to 150% of normal x rays), but that is due to the statistical nature of radiology. We agree with Mr Leaman that our SHOs do a fine job but this paper emphasises that they need support and other systems to reduce the error rate.

**CHRIS A J MC LAUCHLAN**
Royal Devon and Exeter Hospital, Exeter

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**Curriculum based teaching**

**EDITOR,—**We were interested by the article by Davies et al6 on their experience of curriculum based teaching.1 We too have a curriculum based programme. It is organised by a committee of four (two consultants and two trainees) and all of its members have accredited teaching skills, for example advanced life support instructor, City and Guilds teacher’s certificate 7307. Consultants also contribute to the programme on the grounds that if you wish to benefit from the meetings you should be prepared to contribute to them. Two tutorials are covered in each afternoon meeting, with time built in for discussion. Although we do not attempt to rank our meetings we ask participants to evaluate them at the end of each tutorial.

The speakers are either consultants who present a topic related to their area of expertise and interest, or trainees who are required to extend their knowledge base by addressing an allocated topic from the FFCAE curriculum, but avoiding areas where they are likely to have a large knowledge base. The trainees are given six months’ notice, allowing comprehensive research on their topic. As regards content, all presentations have to be referenced from the most up to date sources and to be of the standard of Rosen et al and the Oxford Textbook of Medicine. It is also a requirement that the presentation should make clear any audit or resource implications.

Throughout the course there is standardisation of format: all presentations to be on Microsoft PowerPoint and be accompanied by a document on Microsoft Word or WordPerfect. Participants must choose font type, point size, and the use of colours.

At the end of the each meeting, which is informal and allows for constructive debate, the speaker receives a summary of peer group evaluations (trainees only). The Word and PowerPoint files are copied from the presenter’s computer.