LETTERS TO THE EDITOR

Exsanguinating pelvic fractures

Editor,—The resuscitation protocol for patients with multiple trauma (fig 1, algorithm) in the article by Meek and Ross on managing exsanguinating pelvic fractures in the UK is contrary to the discussion on imaging the patient. Computed tomography is able to detect associated intraperitoneal bleeding in exsanguinating patients with pelvic fractures, the authors state. However, the differentiation between a pelvic fracture and an intraperitoneal bleed may be difficult in practice. The authors also stress the importance of considering the trauma mechanism. The risk of the patient sustaining other injuries, such as renal injuries, is also elevated. In our experience, computed tomography has been very useful in such rare cases. We feel that the tentative conclusions by Meek and Ross do not take into consideration the differential diagnosis of pelvic fracture with intraperitoneal bleeding.

Dale et al attempted to randomly allocate primary care patients to a given doctor (general practitioner (GP) or A&E training grade) during certain sessions in the A&E department. They point out that this system broke down because the doctors were overburdened during some periods of time. To avoid saturation of the A&E department, the treatment of these patients was alternated between the registrars and the A&E doctors. Although this method of practice is, of course, important, it requires consideration in terms of the experience and training of other senior house officers. Differences in investigations, referrals, and the levels of patient satisfaction expressed during follow up strongly support the argument that GPs can treat certain types of patient more cost effectively in the A&E department, without deleterious effects on patient outcome and satisfaction. This conclusion is corroborated by other studies, in particular the study conducted by Murphy and colleagues in Dublin.

The effect that experience has on a doctor's ability to assess patients, either GP, senior house officer, or registrar, method of practice is, of course, important. However, this does not require consideration in terms of the experience and training of other senior house officers. Differences in investigations, referrals, and the levels of patient satisfaction expressed during follow up strongly support the argument that GPs can treat certain types of patient more cost effectively in the A&E department, without deleterious effects on patient outcome and satisfaction. This conclusion is corroborated by other studies, in particular the study conducted by Murphy and colleagues in Dublin.

The authors reply

We thank Dr Brown for highlighting an apparent contradiction in our review and agree with his comments about computed tomography. However, we remain concerned that the imaging of pelvic fractures in patients with haemodynamically stable pelvic ring fractures is necessary in clinical practice. The combination of clinical findings and other imaging modalities is important in determining the need for intervention.

The authors and Professor George Freeman reply

Mr Egleston (rightly) points out the tentative nature of our conclusions in our review paper. This was a function of the limited information available on the actual costs associated with pelvic fractures and the cost of delivering care.

Finally, we would like to support the idea that senior house officers and specialist registrar training programmes should increase the emphasis on primary care and should include a secondment in general practice. This could lead to a better understanding of the current care available for effectively managing this significant proportion of the patient population.


Primary care problems in patients attending a semi-rural accident and emergency unit

Editor,—We were interested to read the article by Cottingham,1 however his article appears to be based on false premises and contains a number of serious inaccuracies. The aim of his study is described as being to...