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 abdomen in the text. We are told that clinical examination is less reliable in multiple trauma to identify occult retroperitoneal structures such as this patients. It should also specifically include more causal cuts to provide additional detail regarding the configuration of the pelvic fracture, and may allow three dimensional bony reconstruction. Although the main concern of the paper was the management in exsanguinating patients with pelvic fractures, the algorithm would be strengthened by adopting this key alternative of computed tomography in investigating haemodynamically stable patients. Otherwise, the paper was an excellent review of management priorities in this potentially troublesome group of unstable trauma patients.

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The authors reply

We thank Dr Brown for highlighting an apparent contradiction in our review and we agree with his comments about computed tomography in stable patients, although our review was concerned with the exsanguinating patient. In addition to close observation, emergency computed tomography of the pelvis, abdomen, and other areas as indicated in these stable patients is indeed invaluable. The box labelled “Watch very closely” should read “Watch very closely, computed tomography of pelvis and abdomen.”


Cost of alternative models of care for primary care patients attending accident and emergency departments

Editor,—Among the tentative conclusions that Leydon et al make in their review paper is the suggestion that primary care physicians working in accident and emergency (A&E) departments conduct fewer investigations and make fewer referrals than A&E doctors. In coming to this conclusion they refer to four papers: three from the United Kingdom, and one from the Republic of Ireland. It would be valuable to examine the findings of two of these papers more closely before accepting the conclusion of Leydon et al uncritically.

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 primary care doctors were excessive at time additional doctors assisted in the treatment of these patients. In addition registrars assigned to treat primary care type patients were often prevented from completing these sessions by departmental circumstances. The registrars in this study identified a higher percentage of fractures in the primary care patients (9.3%) than the GPs (6.6%). This last piece of information gives rise to a number of possibilities, among them that the triage process was not rigorously applied, which in turn implies that the registrars and GPs dealt with different patient populations.

Murphy et al in their randomised controlled trial carried out in St James’s Hospital, Dublin, make the valuable point that the lower rate of investigation and referral by GPs may reflect the fact that the doctors were more experienced than the senior house officers they worked with. Murphy and his coauthors avoided triage bias by looking at all category 3 (semiurgent) and category 4 (delay acceptable) patients. They did not attempt to separate “primary care” from “A&E” patients. This prudent measure avoids the apparent error of Dale’s paper and reflects the reality that there is no triage officer who could be looked at appropriately in an A&E or primary care setting, depending on the aptitude of individual GPs.

It is likely that GPs working in A&E look after more urgent patients and cost efficiently than less experienced A&E doctors. However, it is also a fact of life in most of the country’s A&E departments (even those which provide a designated primary care service staffed by GPs) that A&E doctors will continue to look after some primary care problems. This being the case it would be useful to increase the emphasis on primary care in senior house officer and specialist registrar education programmes. It also highlights the desirability of a primary care secondment in the specialist registrar training programme. These measures could lead to a reduction of unnecessary investigation and admission by junior A&E doctors.

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The authors and Professor George Freeman reply

Mr EGGLETON (rightly) points out the tentative nature of our conclusions in our review paper. This was a function of the limited information on the actual costs associated with some of the primary care interventions reviewed. Notwithstanding, this hurdle we proceeded to systematically examine the evidence for the inclusion of representatives of different models of care in the primary care department. EGGLETON’s suggestion that there may have been a difference in the case mix dealt with by GPs and hospital doctors in the Dale study is valid. Indeed Dale and his colleagues high-lighted this in this article as well as in their own.

Further, the size of the study, the significant difference in per case costs between GP and hospital doctors, and the smaller percentage of patient satisfaction expressed during follow up strongly supports 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 his colleagues in Dublin.

The effect that experience has on a doctor’s method of practice, whether GP, senior house officer, or registrar, is demonstrated in our study of Dale et al. This raises some important issues for evaluation. Do primary care doctors need to be “watched very closely”?

Cost of alternative models of care for primary care patients attending accident and emergency departments

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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
determine the differences in use of resources by accident and emergency (A&E) primary care attenders between inner London and Eastbourne, and yet data relating to resource use were not collected. He misrepresents the purpose and findings of the A&E Primary Care Project at King's College Hospital, and his conclusion is fallacious.

The purpose of the King's project was to "compare consultations made by medical staff in the A&E department and vocationally trained local GPs [general practitioners] for patients assessed as having primary care needs". Although our study was based in an inner city department, it is inaccurate for Cottingham to suggest that we see the use of the A&E department by patients with primary care problems as just an inner city problem. Cottingham misinterprets the statement made in the report of the Royal Commission on the NHS in suggesting that the primary care use of A&E was seen as only an inner city problem, and he was wrong in suggesting that our study was intended to validate the Royal Commission's view.

We were also puzzled by why he suggests that we have "promulgated" the triage criteria we developed for our study. As we stated in our paper, "the development of a prospective method for identifying patients attending A&E with an accident and emergency department: a necessary step towards implementing service developments". We have never suggested that the triage criteria are relevant outside this context.

It comes as no surprise to us that the primary care workload might be similar in some A&E departments outside inner London to the levels found at King's. While we stated "a need to be cautious in considering the applicability [of the King's findings] to other A&E settings", we also argued that "the cost effectiveness [of employing GPs in A&E] is likely to reflect not only the characteristics and experience of the GPs employed in these services but also a range of local circumstances, such as demand and management and operational issues".

We find the last sentence of the final paragraph of the discussion and the conclusion illogical. Cottingham has demonstrated that by using our criteria the Eastbourne A&E primary care workload is similar to that at King's. To conclude from this that our triage classification is not valid makes no sense. The only conclusion that can be derived from this study is that it provides evidence to support implementing an A&E primary care service development at Eastbourne.

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The author replies
Thank you for asking me to respond to the comments by Ed Glucksman. There are a number of points which have been raised that I would like to address. With regards to their comment on resource utilisation, I did not collect data on resource use as we do not have a GP service within the A&E unit. Clearly this is part of the large important study, the Primary Care Project, but the point of the paper, as in their title, is the prospective identification of patients. I apologise if they feel that I have misrepresented their work; it was certainly not my intention so.

I have not suggested that Dale et al regard such use of services as an inner city problem. I wrote, "It is thought that such problems are worst in deprived areas of inner cities." The existence of such problems seems to be a generally held view in the A&E world and I have not attributed the statement to anyone.

I have quoted the Report of the Royal Commission on the NHS within the context of their paper and with reference to it. Their results and conclusions in my analysis seem to lead one to that conclusion.

To promulgate means simply to set forth or to publish. As I explained, I have simply applied their criteria to my patient population.

I do not believe my conclusion to be nonsensical; since their paper has been published more precise tools have been developed that will lead to more accurate classification of patients. Perhaps we can agree to disagree. I am sure that Dale and Glucksman would also consider this research to be integral into this very important area of patient preference.


The early management of meningococcal disease

EDITOR.–We commend the publication of a review of the early management of meningococcal disease. This is certainly a condition in which the doctors of first contact must have a knowledge out of proportion to their previous experience.

It was disappointing, however, that this review focused on purpura as the sole cutaneous manifestation of meningococcaemia. It is almost universally recognised that a febrile tachycardic child with a purpuric rash should be treated as having meningococcal septicaemia. There was, however, no mention of less specific skin appearances of meningococcal disease in this review.

In a prospective study of meningococcal disease presenting to hospital 13% had a maculopapular rash only. The authors could not find any evidence that meningococcal disease presenting with a maculopapular rash alone was less severe than that presenting with purpura.

Another prospective study found 22 out of 126 children presenting with meningococcal disease had maculopapular rash rather than haemorrhagic rashes. This group reported a fatal illustrative case of meningococcaemia misdiagnosed as measles in the presence of a maculopapular rash. The delayed or misdiagnosis of meningococcal disease in the presence of a maculopapular rash has been reported elsewhere.

The algorithm presented in the review offers false reassurance. The underlying message should be that the differential diagnosis of a toxic febrile child must include meningococcal disease whether they have a purpuric rash, a maculopapular rash, or no rash at all. To take reassurance from the absence of purpura or petechiae shows a lack of understanding of the spectrum of presentation of meningococcal disease.

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Ecstasy related trauma

EDITOR.—Each year there are an estimated 50 000 deaths and 1.5 million casualties as a result of road traffic accidents within the European Union,1 and it has been estimated that at least 10% of these victims have taken some form psychotropic medication that may have contributed to their accident.2 MDMA (3,4-methylenedioxymethamphetamine), widely known as ecstasy, is now cited as Europe's second most commonly used illicit drug and is likely to play a steadily increasing part in the aetiology of trauma.3 Over a three month period we treated 16 ecstasy users who had been injured as a result of road traffic accidents. Reckless driving was the cause of all accidents. Impaired mental function caused considerable difficulty in assessing neurological status in seven patients and the systemic effects of MDMA, including sinus tachycardia and pyrexia made general assessment problematic in 10. An array of serious injuries including 25 fractures were sustained by these patients. Eight who required acute surgery suffered no significant anaesthetic complications. We estimate the overall cost of hospital care for this group to be in excess of £50 000.

We believe that greater public awareness of the risks of driving under the influence of MDMA is desirable and advise that accident and emergency staff familiarise themselves with the effects of this drug in order to safely assess and manage these patients.

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