be considered in those patients presenting to an A&E department with features suggestive of migraine.

PAWAN GUPTA
Specialist Registrar
S MOALYPOUR
Consultant
Accident and Emergency Department,
Kingston Hospital, Galsworthy Road,
Kingston upon Thames, Surrey KT2 7RF


The authors reply
The letter from Gupta and Moalypour further illustrates that carotid artery dissection is not as uncommon as had been thought. The range of symptoms recognised as being due to the condition and its diagnosis will no doubt increase as doctors become aware of it and imaging techniques and access to them improve. At present we are still learning the true incidence and the natural history of this challenging condition.

Minor injuries units

EDITOR,—Mabrook and Dale’s paper on the minor injuries unit in Horsham will doubtless be cited as further evidence of the viability of such facilities. However, closer inspection of their data suggests otherwise.

Firstly, we know that 50% of patients attending minor injuries units could have either self treated or seen their general practitioner (GP). This implies that only 3472 of the Horsham patients had a significant injury. Of these, 1342 had to be seen by the accident and emergency (A&E) consultant, 234 were referred to the major A&E unit, and 93 were referred to the ear, nose, and throat and ophthalmology departments. This leaves just 1803 appropriate patients who were treated by emergency nurse practitioners (ENPs) during the 12 month period. This equates to 3.5 patients per nurse per working day. Hardly an efficient use of experienced nurses.

Secondly, the paper talks about quality but fails to say whether the ENPs accurately managed soft tissue injuries or whether the antibiotics they prescribed were appropriate. Nor are we told how many ENP patients later self referred to their GP or to the major A&E unit. Nor does the planned readmission rate reported (23%) suggest a particularly efficient or confident department.

As the pressure to close small and medium sized A&E units continues, more and more communities will be offered minor injury units instead. The public should understand that such units are both understated and inefficient of resources.

A M LEAMAN
Consultant in Accident and Emergency Medicine,
Princess Royal Hospital,
Apley Castle, Telford,
Shropshire TF6 7TF


The authors reply
We were pleased to find that McAnulty and Robertshaw’s work regarding oxygen concentration during simulated cardiopulmonary resuscitation confirms our research, and are grateful for the opportunity to discuss our methodology in greater detail.

With the manikin and ventilation bag set as explained in our previous letter, the oxygen level recorded at the sternum and apex paddle positions and also at the mouth remained at 21%. Each position was observed for 10 minutes and the oxygen reading was noted to stabilise after two minutes. Therefore, with the analyser raised above the trolley around the manikin’s anterior, there is no change in oxygen concentrations.

Referring to both our earlier letter on the subject and supporting letter by Dr Ward, the real debate is not how far to remove the ventilation bag before defibrillation but whether one should remove the oxygen at all before defibrillation. Which is the greater risk? The risk of fire due to defibrillation over an oxygenated area, or the risk of dislodging the endotracheal tube, reducing oxygen flow to a patient in dire need, and delaying life saving defibrillation?

As a training issue, we concur with Dr Ward, “awareness of the problem is likely to reduce the incidence [of fire],” and Robertshaw and McAnulty, “it is most important to avoid arcing by ensuring correct placement of paddles and electrolyte pads before defibrillation…”.

In summary, the risk of fire is remote in properly performed defibrillation; the risks to the patient caused by delaying the time to remove the oxygen, and the possibility of dislodging the endotracheal tube before defibrillation are too great. Whether in the accident and emergency department or the intensive care unit, we reassert our belief that oxygen should not be removed before defibrillation.


Child Protection Register—time for change

EDITOR,—The Child Protection Register neither protects children nor is it a good register. It is used in accident and emergency (A&E) departments across the country several thousand times a day as an investigation. What is the sensitivity and specificity of this test, what positive or negative predictive value has it got?

Many, if not all, A&E department clinicians...
would acknowledge it is difficult to assess objectively a child with a bruise who is on the register. Innocent accidents befall those on the register as well as those who are not. The corollary, the false negative, that because the child is not on the register excludes the injury from being non-accidental is well recognised.

What other tests in clinical practice are so emotive? Being on the Child Protection Register in Cleveland has different connotations to being on the Child Protection Register in Dorset. Would the same be said of an abnormal full blood count?

As a test it is also time consuming and unwieldy and is analogous to former red telephone boxes—large, clumsy, and frequently broken! It would be a more useful resource if it was presented as a relational database—an upgradeable CD-ROM for example, or even online. A national database without regional boundaries. A database which not only displayed those currently registered but those who have been on the register in the past two or so years would be useful; with surnames of both parents in cases of divorce/separation.

Having detailed its weaknesses can we drop this test from practice? Probably not, the Child Protection Register is so well known that if a child with non-accidental injury was discharged from an A&E department without referral to the register the media would have a field day.

Use of the register would flourisher at the first hurdle were it to be subjected to "best evidence topic" appraisal, yet it is quoted in the most recent textbook of Emergency Medicine.

Finally, but the most important question: does the presence on or absence from the register affect practice? An experienced A&E department clinician is likely to be referring a child on criteria other than his or her status on the register. Research is needed to establish the Ottawa ankle rules of non-accidental injury—a validated scoring system that predicts/excludes non-accidental injury, which can be used both by A&E clinicians and paediatricians—who don’t see 50 innocent injuries daily.

MARK F NICOL
ADRIAN HARRIS
Accident and Emergency Department, Royal Devon and Exeter Hospital (Winford), Barrack Road, Exeter EX2 5DW

Relatives in the resuscitation room

EDITOR,—I read with great interest the paper by Barratt and Wallis, which adds much to the debate regarding the merits of witnessed resuscitation.1 As with all interesting papers it raises as many questions as it seeks to answer. In the first instance, it is uncertain from the paper if the facilities currently recommended for witnessed resuscitation were available to the surveyed relatives, as per the guidelines from the Resuscitation Council.2 Many, obviously including the Resuscitation Council working party, feel this may alter uptake or desire for uptake of the offer to witnesses.

Secondly, no demographic data are available regarding the non-responders, especially concerning type and location of cardiac arrest. For example, if survival rates for this type had higher response rates,1 and the reasons for declining to answer what could be a potentially emotive questionnaire would be most interesting.

Barratt and Wallis’ paper furthers the case for witnessed resuscitation, challenging previ-

ous often entrenched viewpoints.1 This must be commended as witnessed resuscitation is, in reality, common sense. Nearly half of the respondents in this study, as is most likely in real life, had already been with their relative during the earliest and often most traumatic moments of resuscitation. Barratt and Wallis give us much valuable information but as yet we still do not have all the important answer to one of the most important questions in this area: Why does a relative wish to be a witness to their loved one’s resuscitation?

RUSSELL BOYD
Specialist Registrar, Accident and Emergency Department, Hope Hospital, Stan Lane, Salford M6 8HD

CD-ROM REVIEW

Mosby’s Emergency Medicine CD-ROMs, volume 1 (adult) and volume 2 (child). Single user £250+VAT per volume (both volumes for £304+VAT). Mosby Yearbook Inc and Folio Corporation, 1995. (Available from Healthworks Ltd. 30–38 Dock Street, Leeds LS10 1JF, UK; e-mail: sales@d-access.deamon.co.uk).

Immediate access to a range of reference textbooks is essential in any accident and emergency (A&E) department but so often the most useful books tend to be unavailable having been “borrowed”. These two CD-ROMs contain a remarkable collection of some of the best emergency medicine texts and papers and may well prove an answer to this problem especially now more sophisticated technology is available in many A&E departments. The adult volume contains the entire text and illustrations from the Mosby titles: Emergency Medicine (Rosen), Diagnostic Radiology (Rosen), Clinical Dermatology (Habif), Emergency Medicine Review (Thomas), Annals of Emergency Medicine (1990–94). The paediatric volume includes: Pediatric Emergency Medicine (Barkin), Pediatric Dermatology (Weston), Pediatric Emergency Medicine Review as well as Annals of Emergency Medicine (1994) and Yearbook of Emergency Medicine (1990–94).

The computer system requirements are a 386 PC (or a Macintosh) with 4 MB of RAM and both CDs were very easy to load and use. A short manual is included and after 10 minutes I was able to use various advanced searching modes and it proved surprisingly easy to locate information on various topics. The text was easy to follow and most illustrations including x rays were well reproduced on the screen, however some of the dermatology pictures were lacking in clarity. A major drawback was that in many chapters permission had not been obtained to reproduce the original book illustrations; more than half of the x rays from a book chapter on cervical spine injuries were simply absent, but there was no indication of this in the accompanying manual or promotional material. Also, some of the books contained on the CDs are now available in later editions in book form.

The inclusion of the Annals of Emergency Medicine and the Yearbook of Emergency Medicine is definitely a bonus in being able to search rapidly for the latest research in emergency medicine but more comprehensive dermatology atlases in both volumes would be useful as well as an advanced book on electrocardiograms. The self assessment reviews included are useful for educating junior staff and the inclusion of the paediatric emergency medicine texts are leaders in their fields.

So many illustrations are missing that I cannot yet recommend these CDs but if this problem could be overcome (and the latest editions of the relevant texts included) then I would regard them as basically essential for all A&E departments and certainly useful for higher trainees and consultants to have their own copies.

FRANCIS ANDREWS
Specialist Registrar, Accident and Emergency Medicine, Leeds


1999 Global theme issue

Every year the Journal of the American Medical Association coordinates a theme issue involving medical journals internationally across the range of specialties.

The theme for November 1999 will be “Impact of New Technologies in Medicine”.

The Journal of Accident and Emergency Medicine welcomes submissions of review articles and original papers for publication on this topic. Papers should reach the editorial office by 30 June 1999.

Spring Meeting of the British Paediatric Accident and Emergency Group

13 April 1999, University of York

This is a one day meeting in conjunction with the Paediatric Intensive Care Group and is held within the third Spring Meeting of the Royal Colleges of Paediatrics and Child Health (RCPCH), 13–16 April.

Attendance at the meeting by non-RCPCH members is encouraged.

Details are available from the RCPCH, 50 Hallam Street, London W1N 6DE or from Dr B Phillips, Accident and Emergency Department, Royal Liverpool Children’s Hospital NHS Trust, Alder Hey, Eaton Road, Liverpool L12 2AF.