LETTERS TO THE EDITOR

Accident and emergency medicine or emergency medicine?

EDITOR,—As trainees in emergency medicine, we welcome Laurence Rocke’s suggestion to re-open the debate on the name of our specialty.1 We would support the dropping of the clumsy “accident” and “prefix” for the following reasons: it is a mouthful to say; it is redundant since most accidental injuries can be considered emergencies, if not by the physician then at least by the patient; and it carries with it historical connotations of being an orthopaedic subspecialty, reinforcing the attitudes that many other specialists unfortunately continue to hold towards us.

We do not know what the response of the Royal Colleges of Physicians will be to the problem of increased subspecialisation within general (internal) medicine and the lack of acute care physicians,2 but if they secure the right to the name “emergency medicine” we are going to experience a serious identity crisis. Our vision of the future in the specialty is one of increasing intervention (where appropriate) in the emergency department, and of growing credibility as specialists. We acknowledge gratefully the enormous achievements made by our senior colleagues in creating and building acute care and emergency medicine into what it is today; as the next generation of consultants we intend to honour their efforts by continuing to raise the prestige of our specialty and to attract the highest calibre trainees. To this end we suggest that bringing ourselves into line with much of the rest of the world by renaming the specialty “emergency medicine” is an important and logical step. This window of opportunity may never be open again—it is important to shape our specialty by design, not by default.

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Use of the Cochrane Library by emergency physicians

EDITOR,—Given that systematic reviews may be considered the best form of evidence (costing £20–70K per review) it is important to establish that this evidence is reaching frontline clinicians. The rapidly expanding Cochrane Library contains a register both of systematic reviews and controlled clinical trials. A postal questionnaire was sent to all trainees and trainers in emergency medicine in the Wessex and South West regions; 50/55 (91%) replied. Twenty-four of the 50 had used the Cochrane Library, although use was infrequent; typically it was twice or less during the preceding three months.

The questionnaire provided the conclusions of 14 systematic reviews from the Cochrane Library relevant to emergency medicine, asked the respondents if they knew of each conclusion and, if yes, how they had acquired that knowledge (Cochrane Library, journal club, reading journals, teaching, other).

Of 700 possible responses, 405 responded “yes”, however, in only 10% of these responses was the Cochrane Library the source of that knowledge.

The Cochrane Library is used infrequently by emergency physicians, although more than that reported by other groups. In addition it is clear from these results that the awareness of the conclusions of published systematic reviews can be improved. It is essential that the secondary sources of best evidence are disseminated to emergency physicians and a major step forward is likely to be the making of the Cochrane Library available in full on the Internet (http://www.cochrane.co.uk). The undertaking of the Journal of Accident and Emergency Medicine to publish relevant articles in the journal scan, including systematic reviews, from the journal Evidence-Based Medicine is also an important development.

We wish to thank all the emergency medicine trainers and trainees in the Wessex and South West regions for their excellent response to our questionnaire.

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Journal clubs

EDITOR,—Carley et al rightly demonstrate the potential benefits of a modified journal club that embraces evidence based medicine principles.1 However, it appears that they place greater emphasis on journal reviews rather than best evidence topic reports. Yet it is the latter that is of paramount importance in learning, and which addresses individual patient problems directly.2 Journal scanning, even in groups, does little to enhance continual professional development.3 For this reason greater improvements are likely to be made in searching the literature if all journal club participants search individually and compare strategies and yields with that of a chief librarian.

An alternative “triple jump” format for a journal club would first establish the most important question (arising from that week’s clinical practice), secondly compare “hits” from each individual’s search strategy for the question selected the previous week and finally, critically appraise the key paper(s) from the question agreed a fortnight earlier.

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The authors reply

If our previous papers give the impression that we place more emphasis on journal scanning than best evidence topic reports (BETs) then appearances are deceptive! A large part of the work of the journal club revolves around the conception, planning, searching, and presentation of the BETs themselves, that are the greatest influence on our practice.

Dr Lloyd’s first point regarding the poor yield from an individual doctor “journal scanning” is true. Indeed this has led to the development of secondary publication journals such as Evidence-Based Medicine, and for many specialties this is clearly the way forward. Unfortunately, I do not think emergency medicine is ready to go down this route yet. For example when I tested the first 50 BET topics against the evidence based journals available on CD-ROM I was unable answer any of our questions. The systematic scanning of journals by members of the group selects only those papers worthy of consideration. This same rationale is used by the evidence based medicine publications.

Furthermore his suggestion for a triple jump approach is reasonable and therefore could be a suggestion to improve the BETs based on the book by Sackett et al.3 In fact these ideas were some of the principal starting points for the journal club. However, experience has tailor made our methods to emergency medicine.

We prefer to allow members of the journal club to investigate a topic of their own interest rather than one selected by the group. Invariably members select topics closely linked to duties they have personally seen; this makes the process less of an academic exercise and more clinically relevant for those tackling the BETs.
As regards searching we already compare search strategies between two people, at least one of whom is an experienced MEDLINE searcher. If we had an interested librarian then we would probably use one. Lastly, I believe that for the entire journal club to critically appraise all the papers for the BETs is impractical. Searches often produce large numbers of papers, which we could not appraise fully within an hour. To maintain and teach appraisal skills the club carefully appraises the papers selected from the journal scan.

We do not claim to have the perfect model for an “evidence based journal club”, although we do have a model tailored to the unique problems of emergency medicine. I would hope that other clinicians might adopt and develop our ideas further, perhaps tailoring their own clubs to local circumstances.


Securing intercostal drains

EDITOR,—This letter describes a method for securing intercostal drains. One of the commonest problems encountered with intercostal drain insertion is of securing the drain adequately. A chest drain that falls out is potentially dangerous and is distressing for the patient. A chest drain fixed in this manner is very unlikely to fall out. This technique was observed while working in the Tygerberg trauma unit in Cape Town, South Africa. There is a wealth of experience in managing chest drains in South Africa. This method is suitable for any intercostal drain greater than or equal to size 26. It also allows the drain to be adjusted once it has been placed.

1. Before the procedure a 1 cm cylinder is cut from the tip of the portacath (the floppy tube that connects the intercostal drain to the bottle on the floor) (see fig 1).
2. The chest drain is swabbed with iodine for lubrication and the rubber cylinder is passed over the drain to the required depth of insertion. This is made easier if the trochar is retained. If the drain is swabbed with iodine, there are no problems in mounting the cylinder. Failure to lubricate the drain makes mounting the cylinder difficult.
3. The intercostal drain is inserted in the standard manner, so that the rubber cylinder lies flush with the skin of the chest wall.
4. A standard mattress suture is placed.
5. The skin is closed, first on one side of the drain with a surgical knot. Before cutting the stitch, the blunt end of the needle is pushed between the rubber cylinder and the skin, away from the chest. The loose end of the knot and the needle thread are then tied (see fig 2).
6. The procedure is then repeated on the other side.
7. The end result is an intercostal drain fixed by a rubber cuff, which is stitched to the skin (see fig 3).
8. Removal is by cutting the threads overlying the rubber cylinder, and closing the chest with a mattress suture.

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Figure 2 Step 5.

Figure 3 Step 7.

Ingested coins

EDITOR,—The standard practice with ingested coins that are 2.5 cm diameter or less is to ensure that they are not in the upper airway or oesophagus and then to allow them to pass naturally.

We have recently had experience of two patients where this was not the case, relating to the ingestion of coins produced to commemorate the 1998 World Cup. The first case was an adult male who ingested the coin after friends placed it in his beer glass. The second case was that of a 7 year old boy who tried to hide the coin during a mental arithmetic test and swallowed it. Both presented at 72 hours with abdominal pain.

Radiological examination showed the coins to be at the gastric outlet and both required endoscopic removal. Previous literature has suggested that this site of impaction only occurs in patients with either congenital abnormalities of the region or postgastric surgery.1

These souvenir coins do not behave like monetary coins. They are larger in diameter and weigh more (see table 1). We would speculate that the weight of these coins contributes to the inability of peristalsis to move them through the gastrointestinal tract. This theory merits further investigation since it may alter our approach to ingested novel or unusual foreign bodies.

Figure 1 Step 1.