

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.

- 1 Carley SD, Mackway-Jones K, Jones A, *et al.* Moving towards evidence based emergency medicine: use of a structured clinical appraisal journal club. *J Accid Emerg Med* 1998;15: 220-2.
- 2 Mackway-Jones K, Carley SD, Morton RJ, *et al.* The best evidence topic report: a modified CAT for summarising the available evidence in emergency medicine. *J Accid Emerg Med* 1998;15: 222-4.
- 3 Sackett DL, Richardson WS, Rosenberg W, *et al.* *Evidence-based medicine, how to practice and teach EBM.* London: Churchill Livingstone, 1997.

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 drain, 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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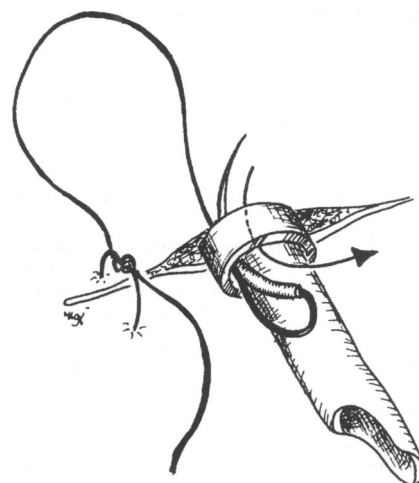


Figure 2 Step 5.

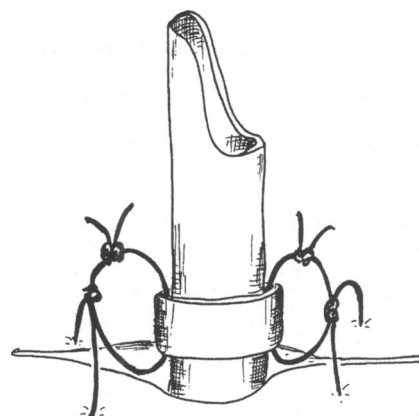


Figure 3 Step 7.

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.¹

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.^{2 3}

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.

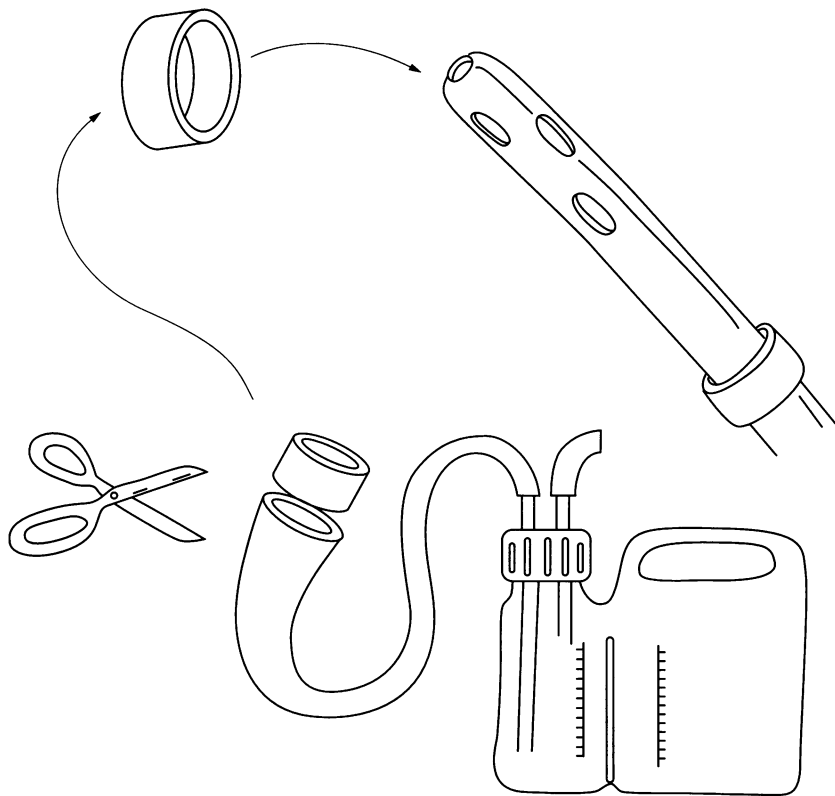


Figure 1 Step 1.