

tion with a unique hospital number it has been easy to work with and has reduced verbal confusion of patients.

Discussion

For a system of alias assignment to work it has to be simple to apply and result in less confusion for both patients and staff. Using a combination of the phonetic alphabet, sex, and date we have designed a system with a number of advantages:

(1) The name is specific to the individual and allows easy communication of the identity. There is a pool of more than 19 000 individual identifying "names" which is unlikely to be exhausted in most institutions. While the system could break down if more than 26 patients of the same sex were admitted in a single 24 hour period, this is unlikely and has not happened in the 13 years the system has been in use in our hospital despite a large number of multiple casualty incidents.

(2) When the identity becomes known this is substituted in the hospital records ("Peter Jones—AKA unknown male Foxtrot 23/4")

while the hospital admission number is retained and is used in all laboratory and radiography data.

(3) Hospital computer searches for people seeking relatives or other agencies has been simplified with inquiries based on either the term "unknown" or probable date of admission.

(4) Although a few other systems of alias assignment have been suggested in the literature,^{1,2} they do not enhance the staff's ability to communicate the identity, are limited by the number of alias names available, and difficulty of computer searches.

We advocate this system as a simple yet effective, tried and tested method for the rapid assignment of a unique alias to critically ill or injured unknown patients.

Conflict of interest: none.

Funding: none.

1 Robinson G, Fortune JB, Wachtel TL, *et al.* A system of alias assignment for unidentified patients requiring emergency hospital admission. *J Trauma* 1985;25:333-6.

2 Blank-Reid CA, Kaplan LJ. A system for working with unidentified trauma patients. *International Journal of Trauma Nursing* 1996;2:108-10.

Faculty of Accident and Emergency Medicine

Consultant appointments, September to December 1998

Gary Cumberbatch	Poole Hospital, Dorset
Ian Stell	Farnborough Hospital, Kent
Sean McGovern	The Ulster Hospital, Northern Ireland
Clifford Mann	Taunton and Somerset Hospital
Dyfrig Hughes	Barnsley District General Hospital
Daniel Wallis	St George's Hospital, Tooting
Fiona Barratt	St Richard's Hospital, Chichester
Julian Webb	Kent and Sussex Hospital
George Little	King's College Hospital, London
James Steele	Altnagelvin Hospital, Northern Ireland
Seamus O'Reilly	Craigavon Area Hospital, Northern Ireland
Mark Prescott	Royal Shrewsbury Hospital
Gerard Lane	Southend Hospital
Ian Greaves	Royal Defence Medical College

Conflict of interest: none.
Funding: none.

- 1 Department of Health. *The health of the nation. A strategy for health in England (1986)*. London: Department of Health, 1992.
- 2 Scottish Office. *Scotland's health, a challenge to us all*. Edinburgh: HMSO, 1992.
- 3 Towner E, Dowswell T, Jarvis S. *Reducing childhood accidents. The effectiveness of health promotion interventions: a literature review*. London: Health Education Authority, 1993.
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- 5 Canadian Hospitals Injury Reporting and Prevention Program. *CHIRPP news*. Issue 2. Ottawa: Bureau of Chronic Epidemiology (Health Canada), July 1994.
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- 9 Ozanne Smith J, Nolan T, eds. *Hazard* (vol 1, editions 1-10, 1988-92, injury data and prevention). Melbourne: Victorian Injury Surveillance System, 1993.

Annual Scientific Meeting of the Faculty of Accident and Emergency Medicine

3-4 December 1999, Royal College of Physicians of London

Call for abstracts

Forms are available from the Faculty of Accident and Emergency Medicine, 35-43 Lincoln's Inn Fields, London WC2A 3PN (tel: +44 (0) 171 405 7071, fax: +44 (0) 171 405 0318, e-mail: FAEM@compuserve.com)

Abstract forms must be received by 6 August 1999

Authors will receive notification of acceptance/rejection

JOURNAL SCAN

Journal scan

Edited by Jim Wardrope; this scan coordinated by Katherine Lendrum

Usefulness of D-dimer, blood gas, and respiratory rate measurements for excluding pulmonary embolism

P Egermayer, G I Town, J G Turner, *et al*

Thorax 1998;53:830-4

Overview—In this study the hypothesis is that the use of a D-dimer assay, arterial blood gas, and respiratory rate measurement will exclude pulmonary embolism and reduce the need for ventilation/perfusion (V/Q) scans.

Design and methods—Observational survey over a one year period at a tertiary referral centre. The subjects were patients referred for V/Q scans for investigation of new pulmonary embolism. Patients under the care of surgeons or the intensive care unit were excluded. The referring doctor was asked to give risk factors and the respiratory rate of the patient. He was also asked to indicate whether the patient had a high likelihood of pulmonary embolism: this was subsequently defined as a high pretest probability. Venous blood was tested in the laboratory for D-dimers using the SimpliRED test an assay based on red cell agglutination. Arterial blood gases on air were taken and defined as normal if arterial oxygen pressure was ≥ 10.7 kPa (80 mm Hg). Pulmonary angiograms were performed at the discretion of the referring team.

Outcome measures—A pulmonary embolism was diagnosed by (1) postmortem finding; (2) positive pulmonary angiogram; (3) high probability V/Q scan with high pretest probability of pulmonary embolism; and (4) after adjudication by a panel of three physicians in high probability V/Q scans without high pretest probability or scans which were difficult to classify.

Results and analysis—517 V/Q scans were analysed of which 6% were reported as high probability, 26% non-diagnostic, 35% low probability, and 30% normal. One per cent were high probability perfusion scans only and a further 2% could not be classified. Pretest probability was high in 216 of 515 patients. D-dimer testing was negative in 249 of 449 patients. Blood gases were normal in 160 of 471 subjects and the respiratory rate less than 20 in 308 of 509 patients.

Forty pulmonary emboli were identified by study criteria. There were 27 deaths but only five postmortem examinations, none of which showed a pulmonary embolism. Angiograms were done in 28 of which eight (33%) showed a pulmonary embolism. High pretest probab-

ity and high probability scan identified 28 and panel adjudication identified four emboli after considering 10 scans. Of these 40 pulmonary emboli the D-dimer test was negative in two patients. This gives the SimpliRED test 95% sensitivity and 54% specificity. The negative predictive value for each test and for tests in combination is 0.95 or above. In particular a normal SimpliRED and blood gas excluded all pulmonary embolism. A further 68 pulmonary embolisms were diagnosed without fitting the criteria of objectivity and were excluded from analysis. The authors conclude that the SimpliRED test could be used to diagnose which patients do not have a pulmonary embolism particularly if used with arterial blood gases. This could potentially reduce the number of V/Q scans.

Critique—The major problem, as in all studies of pulmonary embolism, is the absence of a reliable easily usable "gold standard" to define those patients *with* and those *without* the condition. In any study of a diagnostic test the "gold standard" is key to the generation and interpretation of the results. The diagnostic criteria allowing entry to the study identified 40 patients as having pulmonary embolism, but a further 68 patients who were clinically diagnosed as having pulmonary embolism but did not meet the diagnostic criteria were omitted from the study. In essence it appears that patients with high probability scans or positive pulmonary angiograms were included. Previous studies have shown that pulmonary embolism occur in a third of non-diagnostic V/Q scans.

Not every investigation was done on every patient and the reproducibility and validity of each is questionable. The SimpliRED test is less sensitive than an ELISA test for D-dimers but is more convenient. The study relies on the referring doctor measuring respiratory rate—do we do this accurately? Arterial blood gases were not measured in air in 8% of patients.

The prevalence of pulmonary embolism is low in this study because of the inclusion criteria. There is little information on the 68 pulmonary embolisms (13% of the sample) diagnosed by other means. This significantly reduces the reliability of the study conclusions.

At present guidelines used to exclude a diagnosis of pulmonary embolism have not been adequately tested, but this study is an important further indication that a normal respira-

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tory rate and normal blood gases have high, although not perfect, predictive value in excluding pulmonary embolism. D-dimers can be measured at the bedside and are practical in an accident and emergency setting. In this study no patient with a negative D-dimer, normal respiratory rate, and arterial oxygen pressure >10.7 kPa had a pulmonary embolus.

Safety and effectiveness of nurse telephone consultation in out of hours primary care: randomised controlled trial

V Lattimer, S George, F Thompson, *et al*
BMJ 1998;317:1054-9

Overview—The telephone advice line NHS Direct is to be available to the population of England by the year 2000 to provide clinical advice, general information, and referral to other NHS services. There is little evidence of the benefits of telephone advice, its safety, and its effects on workload.

Objectives—To determine whether there was statistical equivalence in safety and effectiveness of a nurse led telephone consultation service compared with the standard telephone system operating within a general practice cooperative during out of hours periods.

Design—One year block randomised controlled trial consisting of 156 matched days and weekends in 26 blocks. Random number generator assigned intervention. The pattern of intervention was blind to the general public.

Setting—A general practice cooperative, with a combined population of 97 000 patients, in rural Wiltshire served by one hospital.

Methods—Nurses were trained for six weeks in telephone consultation. During intervention periods a receptionist took patient details and passed all calls to a nurse (nurse group). The nurse, aided by a computerised telephone advice system, managed the call herself, arranged contact with the general practitioner (GP) by telephone, at the surgery or home, or contacted ambulance services. All calls about infants under 1 year and second calls about the same patient on the same day were referred to the GP. During control periods a receptionist took the same details and passed on calls to the GP (GP group). Records from the Office for National Statistics on deaths and local hospital attendances were matched for patients telephoning manually and by computer.

Outcome measures—Adverse events were defined as the: (1) number of deaths within seven days of the call; (2) number of hospital accident and emergency (A&E) attendances within three days; (3) number of hospital admissions within 24 hours and (4) within three days of the telephone call.

Analysis—Sample size was calculated using death as the worst adverse outcome, the known death rate, and an estimate that 10% of the study population would contact the cooperative out of hours during the study time. Limits of equivalence between intervention and control groups were set at 80%–125%. The observed number of events in the control group was adjusted to account for different numbers in each arm of the study. Confidence

intervals for deaths were based on total number of patients but for attendances on the total number of calls. This allows more than one admission per patient and for a patient to be in both arms of the study.

Results—10 134 patients used the service making 14 492 calls. There were 7184 calls in the “nurse group” and 7308 in the “GP group” with no differences between the age and sex of patients in each. Children and the elderly were over-represented in the study in comparison with the study population. In the “nurse group”, the nurse dealt with 50% of calls, in 15% a doctor gave telephone advice, 18% were seen at home, and 16% in the surgery. In the “GP group” a doctor dealt with 50% of calls by telephone advice, but more patients were seen at home (24%) or the surgery (26%). There were more deaths or admissions to hospital in the “GP group” but more attendances to the local A&E department in the “nurse group”. Altogether 412 patients attended A&E in the intervention group compared with an adjusted number of 391 in the control group. However the number seen in A&E in the intervention group was within the equivalence limits (374 to 452). The study found that the new system reduced the workload of the GP without increasing the number of adverse events.

Critique—This study is an unusual design because it looks for statistical equivalence rather than difference. The study randomisation is as practical as possible, the study size is calculated and limitations of the study clearly stated.

The results do not include the number of patients in each of the study arms. Over 4000 patients called more than once. It is not clear how many of these were repeat calls for the same problem or for different problems. Were all the repeat calls in the control group because a GP was unavailable or were they all to the intervention group because the patients were unhappy with the advice given? This information should have been available and could have been reported.

It is not known whether the casemix of the control and study groups was the same. Presenting complaint was collected but is not reported. Does this account for the reduction in deaths, and numbers having GP contact in the “nurse group”?

Conclusion—This study shows the nurse consultation system reduces workload for GPs with equivalent risk of adverse events.

How important is this to an A&E department? In this study there was a relative risk increase of attending the A&E department if you spoke to a nurse of 5.6%. However 333 phone calls would be made to increase attendance by one patient. The study can only be generalised using a similar setting, nurses, and “enthusiastic” GPs. The training and the validity of the computer system are important factors in success elsewhere.

It is unlikely that patients who telephone an advice line will be the same as those who telephone a general practice cooperative out of hours. The results of this study cannot be extrapolated directly to NHS Direct. It waits to

be seen whether this service will have an effect on A&E workloads and at what cost.

Lastly, this study was in rural Wiltshire; would the results be the same in an inner city setting with different travel distances to the A&E department, different cultural and socio-economic mix, and different expectations?

Worst headache and subarachnoid hemorrhage: prospective, modern computed tomography and spinal fluid analysis

L B Morgenstern, H Luna-Gonzales, J C Huber, *et al*

Annals of Emergency Medicine 1998;32:297-304

This prospective descriptive study looks at 107 patients presenting with "the worst headache of their lives". It finds that computed tomography excludes subarachnoid haemorrhage in 97.5% of patients (95% confidence interval 0.3 to 8.8%).

A non-contrast computed tomogram identified 18 subarachnoid haemorrhages. A lumbar puncture identified two further subarachnoid haemorrhages.

Headache characteristics in subarachnoid haemorrhage and benign thunderclap headache

F H H Linn, G J E Rinkel, A Algra, *et al*

Journal of Neurology, Neurosurgery, and Psychiatry 1998;65:791-3

The patients studied had a "sudden onset of headache". Within 24 hours of admission the patients were asked standardised questions about their symptoms. Unfortunately it is not stated whether either the patients or the observer were blinded to their diagnosis at this interview. A diagnosis of subarachnoid haemorrhage, perimesencephalic non-aneurysmal haemorrhage or benign thunderclap non-haemorrhagic headache (BTH) was made on the basis of a computed tomogram and lumbar puncture. One hundred and two patients were questioned, 42 had a subarachnoid haemorrhage and 37 BTH. The headache was described as almost instantaneous in 68% of those with a BTH and 50% with subarachnoid haemorrhage. The positive predictive value of instantaneous headache was 0.39 for subarachnoid haemorrhage. In 74% of subarachnoid haemorrhage and 72% of BTH the headache came on in less than one minute. The severity of headache was similar. The speed of onset and severity of headache cannot be used to distinguish subarachnoid haemorrhage from a benign thunderclap headache.

Should inhaled anticholinergics be added to β_2 agonists for treating acute childhood and adolescent asthma? A systematic review

L H Plotnick, F M Ducharme

BMJ 1998;317:971-7

This systematic review looks at 10 published and unpublished randomised controlled trials set in emergency departments. These consider

the use of ipratropium bromide or atropine inhalation in addition to β_2 agonists to treat acute asthma in children aged 18 months to 17 years. The review finds that in school age children and adolescents with severe asthma a multiple dose fixed regimen of anticholinergic added to β_2 agonists reduces hospital admissions and improves lung function. Individual studies had insufficient power to show this. Although relatively homogeneous there was variability on the concomitant use of steroids. Most of the studies were from the USA.

Early active mobilisation of volar plate avulsion fractures

W J Gaine, J Beardsmore, N Fahmy

Injury 1998;29:589-91

One hundred and sixty two patients with 166 volar plate fractures were treated by active mobilisation initiated at their first hand clinic appointment (two thirds within one week of injury). Neighbour strapping and splints were not used; 88% had an excellent outcome regardless of injury severity. Three patients had a fair outcome and none were described as poor. This paper has multiple methodological weaknesses and provides weak evidence. However it raises an interesting question that could be studied in a blinded randomised controlled trial in an accident and emergency setting.

Efficacy of the motor component of the Glasgow coma scale in trauma triage

S E Ross, C Leipold, C Terregino, *et al*

Journal of Trauma 1998;45:42-4

A retrospective review of the pre-hospital records of Glasgow coma score (GCS) in trauma patients found that using the motor component of the GCS alone was equally sensitive and specific to using the full score at identifying patients with a major head injury. Specificity is over 85% but the sensitivity of GCS and the motor component is only acceptable in head injuries with an abbreviated injury score of 5.

Cell count ratio: new criterion of diagnostic peritoneal lavage for detection of hollow organ perforation

J F Fang, R J Chen, B C Lin

Journal of Trauma 1998;45:540-4

Now that blunt trauma patients with solid viscus injuries who are haemodynamically stable may not proceed to immediate laparotomy, hollow organ perforation may be the only absolute indication for early operation. The classic criteria for positive diagnostic peritoneal lavage (DPL) may not identify perforation. Cell count ratio is defined as peritoneal lavage white to red cell ratio divided by the peripheral blood white to red cell ratio. This retrospective review finds that a cell count ratio greater than 1 has a sensitivity of 100% and specificity of 97% for identification of perforation in patients with a classically positive DPL. Prospective validation is required.

A comparison of physical therapy, chiropractic manipulation, and provision of an educational booklet for the treatment of patients with low back pain

D C Cherkin, R Deyo, M Battie, *et al*

New England Journal of Medicine 1998; 339:1021-9

Prospective randomised trial. No significant difference was found between outcomes for

patients receiving McKenzie physiotherapy or chiropractic manipulation. At four weeks the chiropractic group had fewer symptoms than patients given a booklet, but this was not significant. Significance was approached at one year with the booklet being associated with the least favourable outcome. The booklet was the cheapest treatment but resulted in least patient satisfaction.

Child Accident Prevention Trust—literature available

The Child Accident Prevention Trust launched a set of post-accident support literature last October, which is listed below. To obtain any of the leaflets write to the Child Accident Prevention Trust, 4th Floor, 18-20 Farringdon Lane, London EC1R 3AU (tel: 0171 608 3828, fax: 0171 608 3674).

- Getting over an accident: advice for young people.
- Getting over an accident: advice for children over 8.
- Getting over an accident: advice for children aged 8 and under.
- Getting over an accident: how to help children and young people. Advice for parents and carers.
- Providing emotional support to children and their families. Guidelines for professionals. By Alexandra Troyna.

Emergency Medicine

A reciprocal arrangement has been set in place with the *Journal of Accident and Emergency Medicine* and *Emergency Medicine* whereby the contents page of the journals will be published in the respective issues.
The contents page of *Emergency Medicine*, December 1998, appears below.

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Table 1 Details of coins

Coin	Diameter (cm)	Weight (g)
Twenty pence	2.0	5.0
Ten pence	2.3	6.5
Fifty pence (new)	2.6	8.0
World Cup	2.6	8.1

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- 1 Skinner D, Swain A, Robertson C. *Cambridge textbook of accident and emergency medicine*. Cambridge: Cambridge University Press, 1997: 494.
- 2 Mandell GA, Rosenburg HK, Schnauer L. Prolonged retention of foreign bodies in the stomach. *Pediatrics* 1977;60:460-2.
- 3 Cass DT. Gastric retention of a swallowed coin after surgical treatment of pyloric stenosis. *Aust Paediatr J* 1989;25:299-301.

BOOK REVIEWS

Anaesthesia and Analgesia in Emergency Medicine. 2nd Ed. By Karen A Illingworth and Karen H Simpson. Oxford Handbooks in Emergency Medicine. (Pp 397; £45.) Oxford Medical Publications, 1998. ISBN 0-19-262908-5.

Since moving from the UK to work in the southern hemisphere in March 1997, life has taken on a new meaning. Not only do I get non-stop criticism about the state of northern hemisphere rugby (in particular England), but I also find myself regaining control of the airway. Airway management is much more part of the emergency physician's work than in the UK and there is no formal "ownership" of it by anaesthetists. I therefore reviewed the second edition of this paperback with great interest.

The first thing I noticed is that it is lighter and thinner than the first edition by approximately 60 pages. Chapters on pre-hospital care and management of patients with multiple injuries have both gone and there has been some subtle fine tuning in the editing process. Otherwise the book is very similar to the first edition and has the standard format of other books in this series. Personally, I find them easy to read and restful on the retina.

This book makes an excellent introduction to the subject and I enjoyed reading it. It is not, however, a standard reference source or a pocket "bible". For example there is only a superficial mention of topics such as fiberoptic intubation, transtracheal jet insufflation, and no mention of the Combitube or retrograde intubation. Although assessment of potentially difficult airways using the Mallampati criteria is clearly mentioned, as is measurement of the distance between the hyoid bone and the chin, their importance would be emphasised if they were in the same section, rather than approximately 80 pages apart. The

above topics clearly all relate to management of the difficult airway and it would be useful to have an example of a difficult airway algorithm, even if it is actually outside the scope of the book.

There are some minor niggles. The current buzz words "conscious sedation" are not referred to, although sedation is discussed well. My experience in Australasia is that midazolam is often used as an induction agent and I could find no reference to this role. In recent years topical adrenaline and cocaine paste has become popular in the UK for topical anaesthesia (and has been written about in this journal), but I could find no reference to it in the section on topical anaesthesia.

One recommendation slightly surprises me. The authors recommend that a straight bladed laryngoscope can be used up to the age of about 6 months, whereas the Advanced Paediatric Life Support course recommends a straight bladed laryngoscope for at least the first 12 months of life and possibly for the first five years. This reminds me of the old adage that if you were to ask three orthopods how to manage a specific fracture, you'll get five opinions.

Overall, I think this book is an excellent introduction to the subject. Medical students, junior doctors at the start of their training, and nursing staff will all find it extremely useful. The experienced anaesthetist or Australasian nurtured emergency physician will find it an interesting read, but it will not answer all their queries.

GEOFF HUGHES
Wellington, New Zealand

The High Altitude Medicine Handbook. 2nd Ed. By Andrew J Pollard and David R Murdoch. (Pp 165; £17.95.) Radcliffe Medical Press, 1998. ISBN 1-85775-214-7.

Climbing big mountains is a dangerous business. Time was when chain smoking, tweed jackets, and a diet of quails' eggs was regarded as the best prophylaxis for mountain sickness. How medicine has changed.

The second edition of this book is a credit to its authors. They have achieved something that I have often regarded as impossible—writing a text that is as suited to the medical profession as it is to the general public. I have come across their first edition in many strange parts of the world as a lightweight addition to the rucksacks of travellers of all age groups. It is a thoroughly comprehensive review of high altitude medicine, without surplus fact, focusing the reader down to the essentials he or she requires. The book would also be a good companion for those who are travelling to lower levels and to under-developed parts of the world, though I imagine that was not the authors' intention.

How I wish this book had been available when I accompanied an expedition to Everest. I remember frantically searching for a suitable list of items to take. Such lists were few and far between. Yet here, in *The High Altitude Medicine Handbook*, an example of an expedition medical kit is to be found. I would suggest all those providing medical cover for expeditions to remote places seek out this list first before developing their own ideas. Much of the work has already been done for you.

I sense the hand of Pollard—he is a respected paediatrician—in the chapter covering the effects of altitude on children. Thought by some to be an irresponsible act, children nevertheless have increasingly

appeared at high altitude in recent years. The real problem is not that a child is more susceptible to high altitude but that he or she may not be able to express what they are feeling. Death can be very rapid if early symptoms are ignored.

In short, this is an excellent text. Even if the thought of a mountain terrifies you I would read the book nevertheless. The text is ideally sized to fit on a bookshelf, in a briefcase, or even a rucksack pocket. It is just what high altitude needs.

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Consultant Orthopaedic Surgeon, Cambridge

Books received

Key Topics in Anaesthesia. 2nd Ed. By T M Craft and P M Upton. (Pp 360; £21.95.) Bios Scientific Publishers, 1995. ISBN 1-85996-075-8.

Handbook of Drug Interactions. Edited by Lakshman Karalliedde and John Henry. (Pp 935; £55.00.) Arnold, 1998. ISBN 0-340-66204-2.

Respiratory Measurement. By Göran Hedenstierna. (Pp 184; £19.95.) BMJ Books, 1998. ISBN 0-7279-1207-0.

NOTICES

2nd Trauma Care Conference: Improving Trauma Care

7-9 June 1999, Bournemouth International Centre

Further details: Trauma Care Conference Secretariat, c/o Index Communications Meeting Services, Crown House, 28 Winchester Road, Romsey, Hampshire SO51 8AA (tel: +44 (0) 1794 511331/2, fax: +44 (0) 1794 511455, e-mail: icms@dial.pipex.com).

Car Crashes and Occupant Injuries: A Team Approach to Accident Investigation

11-12 June 1999, University of Birmingham
Further details: Jane Loney, Motor Accident Solicitors Society, Bridge House, 48-52 Baldwin Street, Bristol BS1 1QD (tel: +44 (0) 117 929 2560, fax: +44 (0) 117 904 6006).

Correction

We regret that an error occurred in the paper by Pappachan *et al*, Analysis of intensive care populations to select possible candidates for high dependency care (*J Accid Emerg Med* 1999;16:13-17). The legends for figures 1 and 2 were transposed: figure 1 should read "Percentage of scored patients in the LRM group" and figure 2 "Percentage of scored patients with a $\leq 10\%$ risk of hospital mortality as assessed by the APACHE III predictive algorithm".