LETTERS TO THE EDITOR

Anaesthetic training in accident and emergency

EDITOR,—I read with interest the comments of Boyle et al1 regarding anaesthetic training for accident and emergency (A&E) specialist registrars. They suggest that there is a definite advantage to RSI in the training of A&E registrars, and that a single long training session combined with further experience would allow them to perform intubation. I would agree that it is much easier to perform intubation by the laryngoscopy route, I would agree that it o

A child mannequin is available, and a neonatal simulator is being developed. An additional feature available on the METI-HPS was the ability to simulate procedures such as pericardiocentesis of a cardiac tamponade (with “blood” aspiration). It is able to blink and reproduce unilateral pupillary signs. A child mannequin is available, and a neonatal one is being developed.

On the other hand, present the simulated wheezing is not convincing in asthma scenario, and the mannequin cannot simulate grand mal fit, colour change (pallor or cyanosis) or perspiration. Like the Wellington study day, the south west simulator programme for trainees is an innovative extension of traditional emergency department training. We see it as an evolving project that will be carefully evaluated from both the trainer and trainee perspective. A further use of this technology already allows online access to live training sessions broadcast from the centre via satellite (www.multimed.co.uk) to user terminals installed at nine hospital sites in the UK.

We would welcome correspondence nationally and internationally.

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High level simulator

EDITOR,—We were delighted to read of the use of a high level simulator in emergency department training.1 From January 2000, we in the south west have secured three years of funding for the use of the same METI-HPS simulator for specialist registrar training at the Bristol Simulation Centre (www.bris.ac.uk/Depts/BMSC). Like the Wellington group, we face the challenge of creating realistic scenarios of critically ill and injured patients for the purpose of formative assessment. Clear advantages of the high level simulator over traditional advanced life support group scenario training include:

- real time, accurate audio and visual monitoring responses to medical and pharmacological interventions
- the use of videotape assisted hot review
- interactive physiology and pharmacology tuition, particularly in regards to the use of inotropes, anti-arrhythmics, sedatives, opioids and induction agents.

The additional features available on the METI-HPS were perhaps a little understated in the Wellington paper. Voice simulation is standard, and has proved very useful in theatre. As someone who initially undertook a training in anaesthesia with a view to entering higher training in A&E via this route, I would agree that it offers much more than the opportunity to become confident and competent at advanced airway management in the relatively controlled theatre setting. As someone who initially trained in anaesthesia of the various anaesthetic techniques and to gain an understanding of pain management is also very relevant to A&E practice.

The possession of the FRCA, which requires at least 2.5 years of training in anaesthesia, is one of the established ways to enter the A&E specialist registrar grade. Surprisingly, in the current membership list of the British Association of A&E Medicine, only 60 (0.05%) possess the DA (or old primary FRCA), with only 12 (0.01%) possessing the FRCA or equivalent.1 As our specialty continues to develop and accepts more responsibility for early advanced airway management, ventilatory and circulatory support and rapid sequence inductions, both within the A&E department and in the pre-hospital setting, I feel that we should encourage more of our junior trainees interested in a career in A&E to enter the specialist registrar grade via this route.

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Emergency cranial computed tomography

EDITOR,—Harris et al2 apply Rothrock’s criteria3 to a UK population of non-trauma patients. Their abstract concludes “Simple criteria can be usefully applied to patients presenting to an A&E department in this country to target patients most likely to have clinically significant findings on urgent cranial computed tomography”. We believe that the method and findings of the study do not justifiably change in practice implied by this conclusion.

Our methodological concerns are threefold. Information gathered retrospectively from notes and request forms casts doubt over the accuracy and completeness of the symptoms and signs (particularly the symptom of nausea). The inclusion criterion is ill defined (patients who are referred for computed tomography). There is no explanation for the inclusion of nausea (it is not one of Rothrock’s original criteria).

There are also theoretical objections. To be useful, a clinical filter must be applied to unselected patients and include criteria that have a high inter-observer reliability. There is no logic in applying a clinical filter after the decision to investigate has been made.

Furthermore, both studies acknowledge that they do not tackle the problem of subarachnoid haemorrhage in young patients presenting with isolated headache. Surely this is a major consideration in formulating any criteria for computed tomography (CT)?

We applied Harris’ criteria to our prospective series of patients attending A&E with non-traumatic headache (248 patients). Seventy-two CT scans would have been performed. The criteria would have missed three (1.2%) patients with an abnormal CT scan.

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The authors reply

We are pleased that our study has prompted discussion about the use of clinical guidelines for emergency head computed tomography (CT) in the non-trauma population. This is a developing area where little evidence exists.

It was interesting to hear that our modified criteria (any of: (1) GCS<14, (2) focal neurology and (3) headache with nausea or vomiting) would have missed three patients with atraumatic limp. Our protocol was not aimed at identifying "septic arthritis", but identifying children who may be safely discharged home. Our paper demonstrates that this protocol does not appear to miss significant pathology in children presenting with atraumatic limp. Clinical findings were unreliable with further investigation and the subsequent diagnosis resulting from the identification of a markedly increased erythrocyte sedimentation rate. Finally, Aston reported identification of neuroblastoma by detection of anemia on investigation of the limping child.

Therefore, we would advise caution in discharging children presenting to A&E department with atraumatic limp based on history, clinical examination and imaging alone.

ANTHONY MATTICK
Royal Infirmary of Edinburgh

The authors reply

We welcome the interest shown by Bridges et al in our paper. They state that a history and clinical examination are sufficient to select those children, presenting with atraumatic limp, who require further inpatient investigations. They suggest that the routine screening of blood is unnecessary for such children who are discharged, and imply that we are subjecting children to needless venepuncture. However, no objective evidence is offered to substantiate their statement.

In addition, Bridges et al misquote our paper. Our paper states "no one clinical finding or investigation can be used in managing the limping child who attends the A&E department". Our protocol was not aimed at identifying "septic arthritis", but identifying children who may be safely discharged home. Our paper demonstrates that this protocol does not appear to miss significant pathology in children presenting with atraumatic limp. Clinical findings were unreliable with further investigation and the subsequent diagnosis resulting from the identification of a markedly increased erythrocyte sedimentation rate. Finally, Aston reported identification of neuroblastoma by detection of anemia on investigation of the limping child.

Therefore, we would advise caution in discharging children presenting to A&E department with atraumatic limp based on history, clinical examination and imaging alone.

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The irritable hip

EDITOR,—As Mattick et al explain, the irritable hip is a common presentation that requires the exclusion of serious pathology. The protocol described allows appropriate outpatient management of many children. The text describes how no single investigation or examination finding is predictive of septic arthritis. We were however disappointed to see a "blanket" approach to investigations with all children undergoing blood tests.

History and examination are more useful than any investigation. If a child has been unwell, whether febrile or not, septic arthritis should be considered and appropriate investigation and treatment instituted.

Furthermore, in a well child with an isolated painful hip, structural problems need to be excluded with imaging but we have not found blood tests helpful. These are the factors that we use in the individual evaluation of a child with a painful hip in our emergency department.

We appreciate that the comprehensive approach by Mattick et al is aimed at detecting serious disorders but do not agree that blood tests are necessary for every limping child.

SARAH J BRIDGES
LISA L GOLDSWORTHY
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JASON L LOUIS
Mauvois Park Hospital, Tantmon

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Feigning dystonia to feed an unusual drug addiction

EDITOR,—We recently had a patient attend our department repeatedly feigning acute dystonia in an attempt to obtain procyclidine medication. The case illustrates the fact that many medications are abuseable.1 Patients are knowledgeable and may be willing to go to some lengths to obtain them fraudulently. Accident and emergency staff should be alert to this possibility when faced with unusual stories or situations. The psychotropic drug directory is a brief handy reference, which may help in such situations and can be obtained free of charge from Lundbeck pharmaceuticals.2

A 19 year old man of normal appearance, presented on three occasions complaining of neck pain and holding his neck in full extension. Examination revealed a full range of passive neck movements, with no other associated neurological or ocular abnormalities. The patient admitted to previous crack cocaine and marijuana misuse. He further stated that he had recently taken a substance associated neurological or ocular abnormalities. The patient admitted to previous crack cocaine and marijuana misuse. He further stated that he had recently taken a substance...