Anaesthetic training in accident and emergency

EDITOR,—I read with interest the comments of Boyle et al in regard to anaesthetic training for accident and emergency (A&E) specialist registrars. They suggest that there is a definite advantage in spending six months as a “true” anaesthetic SHO as part of the A&E specialist registrar scheme, rather than as a supernumerary extra 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 more than the opportunity to become confident and competent at advanced airway management in the relatively controlled theatre setting. Boyle et al suggest that in anaesthesia offices the chance to gain many other skills that are extremely useful to the A&E trainee, particularly in the resuscitation setting, including the assessment and management of critically ill patients, providing ventilatory and circulatory support where necessary, the use of anaesthetic equipment, invasive haemodynamic monitoring techniques and transportation of critically ill patients. The opportunity to become proficient at the various regional 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%) members possess the DA (or old primary FRCA), with only 12 (0.01%) possessing the FRCA or equivalent. 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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Rapid sequence intubation

EDITOR,—All emergency medicine specialists should be competent in rapid sequence intubation (RSI). We thank the authors for their commitment to training this essential skill.

The simulator experience with video playback could be an extremely powerful teaching aid and aid potential attendant complications. Currently, only a few accident and emergency (A&E) departments in the United Kingdom have access to this expensive tool.

RSI is a skill that is used with short notice and requires confidence and competence to perform appropriately. The cognitive and psychomotor skills needed are unlikely to be retained from a single course. RSI should therefore be taught as part of an integrated training programme. This should include prolonged exposure to intubations during an anaesthetic attachment, a short course simulating the National Emergency Airway Management Course from the USA covering core knowledge, and a process of revalidation and quality assurance.

We feel that the use of simulators would not be practicable for the primary training of the large numbers of UK A&E specialists in RSI. The use of simulators could, however, play a vital part in the regular appraisal and revalidation of individual practitioners once they have completed their training programme. This revalidation of skills and the regular audit of results should form the basis for the essential quality assurance, which this programme would need.

In summary, if we follow the airline pilot analogy, training occurs in the classroom and in the air, and revalidation is the work of the simulator.

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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.

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 been used in thornay bolusys study days run at the Bristol Medical Simulation Centre. The mannequin is also able to simulate needle decompression of a tension pneumothorax (with audible hiss) and successful pericardiocentesis of a cardiac tamponade (with “blood” aspiration). It is able to blink and reproduce unilateral papillary signs. A child mannequin is available, and a neonatal one is being developed.

On the other hand, at present the simulated wheezing is not convincing in asthma scenarios, and the mannequin cannot simulate grand mal fitting 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.multi-med.co.uk) to user terminals installed at nine hospital sites in the UK.

We would welcome correspondence nationally and internationally.


Emergency cranial computed tomography

EDITOR,—Harris et al apply Rothrock’s criteria1 to a UK population of non-trauma patients. Their abstract concludes “Simple criteria can be used safely to select 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 justify the 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 criteria 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 unscreened 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 could have been performed. The criteria would have missed three (1.2%) patients with an abnormal CT scan.

Judging from the differing rates of CT abnormality in the cited studies (35% v 6%), CT rates in the UK are well below those in the USA. Given that we accept a detection rate of 1 of 80 for patients with skull fracture and GCS 15, perhaps we should be scanning more patients with non-traumatic headache not fewer.


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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 abdominal injury. It is unclear whether these were young patients with subarachnoid haemorrhage who, when presenting with isolated headache, we already acknowledged as a problem population.

Our modified criteria are simple, common-sense suggestions that reflect current practice. We acknowledge the retrospective nature of our trial. Having demonstrated that the criteria could be useful, prospective validation is necessary.

HELEN DRAPER
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The irritable hip
EDITOR,— As Mattick et al explain, the irrita-
ble hip is a common presentation that requires the exclusion of serious pathology. The proto-
col described allows appropriate outpatient man-
agement of many children. The text describes how no one 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 feverish 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.

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Topical anaesthesia use in the management of children's lacerations, a postal survey
EDITOR,— The suturing of lacerations of chil-
dren is often di-cult. Infiltration with 1% plain
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The Medic 1 Trust Fellowship
The Medic 1 Trust Fellowship is awarded to facilitate education or research in the field of accident and emergency medicine and may be used for associated travel.

1 The Fellowship is awarded to a doctor or nurse currently working in the field of accident and emergency medicine.

2 Applicants must give details of com-
pleted preparatory work and a planned itinerary. Unsupported proposals of a general nature will not be accepted. Applicants must provide the names of two referees.

3 The value of the award will be a maximum of £2500. The amount of the award will be made on the recommen-
dation of the honorary treasurer and with the approval of the Medic 1 Trustees.

4 The recipient is to be named the Medic 1 Trust Fellow.

5 The recipient will be required to present a written report to the chairman of the Medic 1 Trust within three months of completion of their visit.

6 No individual may be awarded the Medic 1 Trust Travelling Scholarship on more than one occasion.

7 Applications can be made to:
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8 A maximum of one medical scholarship and one nursing scholarship will be made every year.

9 Applications must be received by 31 October in any year.

Application information:

Applications are to be made on the Medic 1 Trust Fellowship Application form available online at www.medic1trust.org. The completed form should be returned to the Medical Trust at the address above. Forms will be available from September 2019. The closing date for applications is 31 October 2019. No applications will be considered after this date.

Applicants are required to provide a working email address for correspondence.

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gather with the inconvenience of its use may be why UK clinicians prefer the safer and convenient lignocaine infiltration. If an agent without cocaine was shown to have similar efficacy to TAC, it may allow more widespread use of TA in the UK.

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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 abusable. 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.

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 he believed to be diazepam. A putative diagnosis of acute dystonia was made and he was treated with 5 mg intramuscular procyclidine. He made a recovery within a few minutes and was discharged.

Feigning dystonia was made in an attempt to obtain procyclidine without being observed.

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NOTICES

13th Annual Congress of the European Society of Intensive Care Medicine
1–4 October 2000, Rome, Italy
Further details: ESICM Congress Secretariat, 40 Avenue Joseph Wybran, 1070 Brussels, Belgium (tel: +32 2 559 03 55, fax: +32 2 527 00 62, e-mail: public@esicm.org, web site: http://www.esicm.org).

Books received


Clinical Toxicology Short Course
30 October to 8 November 2000, Adelaide, Australia
Further details: Dr Julian White, Poisons Information Centre, Adelaide Childrens Hospital Division, Women’s and Children’s Hospital, King William Street, North Adelaide, SA 5006, Australia (tel: +61 8 82047000, fax: +61 8 82046049, e-mail: toxinaus@wch.sa.gov.au, web site: http://www.wch.sa.gov.au/paedm/clintox/courses.html).