LETTERS TO THE EDITOR

Anaesthetic training in accident and emergency

EDITOR,—I read with interest the comments of Boyle et al regarding anaesthetic training for accident and emergency (A&E) specialist registrars. They suggest that there is a definite advantage for RSI, but 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. I do not believe that in anaesthesia or in anaesthesia off the theatre I would 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 prehospital 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 for RSI and its 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 similar to 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, 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 of responses to clinical and pharmacological interventions
● the use of videotaped 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 helpful in thrombolysis 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 pupillary 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.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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Emergency cranial computed tomography

EDITOR,—Harris et al apply Rothrock’s criteria to a UK population of non-trauma patients. Their abstract concludes “Simple criteria can be used 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 justifiy 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 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.

Judging from the differing rates of CT abnormality in the two 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.
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 abnormal CT findings. It is unclear whether these were young patients with subarachnoid haemorrhage who, when presenting with isolated headache, we have already acknowledged a problem population.

Our modified criteria are simple, common-sense suggestions that reflect current practice and are easy to follow. We have not 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. distinguish, 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 one single investigation or series of investigations is necessary.

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 limp child.

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The authors reply

We welcome the interest shown by Bridges et al. in our paper.1 They state that a history and clinical examination are sufficient to select those children, presenting with macrotraumatic 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 limp 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 to A&E. We accept that our protocol has the potential to be reined, making it more sensitive and specific, we are unaware of any robust published evidence demonstrating history and clinical examination alone as being reliable at excluding significant pathology in children presenting with hip pathology.

However, there is evidence demonstrating the pitfalls of relying on history and clinical examination alone. Taylor et al reported in a series of 509 cases of “irritable hip” that history is unreliable in this condition. A recent study identified four cases of occult osteomyelitis, at various sites in the distal limb, presenting to a paediatric A&E department with macrotraumatic limp. Clinical findings were unreliable with further investigation and the subsequent diagnosis resulting from the identification of a markedly increased erythrocyte sedimentation rate. Finally, Aston1 reported identification of neuroblastoma by detection of anaemia on investigation of the limp child.

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

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Topical anaesthesia use in the management of children’s lacerations, a postal survey

EDITOR,—The suturing of lacerations of children is often difficult. Infiltration with 1% plain lignocaine (lidocaine) is commonly used to make the suturing more comfortable. This infiltration may cause pain and render the child uncooperative for the rest of the procedure.

Topical anaesthesia (TA) has been described since 1980.1 The agent commonly used is a mixture of 0.5% tetracaine, 0.05% adrenaline (epinephrine) and 11.8% cocaine (TAC). This method has a similar efficacy to infiltration but is less painful to apply2 and is used widely in the United States.

All 597 accident and emergency (A&E) departments in the UK were sent a questionnaire about their use of TA in children’s lacerations.

There was a 71% response rate. Of the 34% of all responders who used TA, 33% used Emla, 31% used lignocaine and 26% used Atrigel. Less than half of these felt TA was preferable to injection. Only 8% used a cocaine and adrenaline mixture but 91% of those preferred it. TAC was used in 3%.

Most (66%) departments did not use TA. There were many reasons given. The commonest reasons were “no experience” (28%), “TA ineffective” (20%), “slow onset” (10%) and “department protocol” (10%). Three per cent of responders were concerned about absorption.

This survey has shown that only a minority of UK A&E departments use TA for suturing children’s lacerations and, of these, few use agents for which there is evidence. TAC use has been associated with prolonged fitting3 and mortality;4 TA is expensive and contains a controlled drug, the rare catastrophes to-
presenting complaint. On his last visit he was treated with 5 mg intramuscular procyclidine (Kemadrine) is the usual drug used. Procyclidine is an anticholinergic drug whose potential for misuse, although described, is not widely recognised. It is believed to have an euphorant effect. Indicators of misuse include absence of symptoms when a patient is unaware of being observed, dystonia of a static form, the presence of non-organic neurology, evidence of a secondary gain, or symptoms of somatisation disorder. If simulation is suspected, a call to the patients’ general practitioner or to local emergency departments may reveal, that the patient is “shopping”.

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 edgeable and may be willing to go to some

NOTICES

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