

LETTERS TO THE EDITOR

Toxicological screening in trauma

EDITOR,—Carrigan *et al* through the use of toxicological screening suggests a significant prevalence of drug and alcohol use in the British accident and emergency (A&E) trauma population.¹ Our own audit of 351 patients attending St Thomas's Hospital A&E in London, examined the part alcohol plays in the use of radiological investigation for traumatic injuries, found a similar prevalence. However, a simple questionnaire type assessment carried out by the A&E doctor seems to be as effective at indicating alcohol intoxication as blood alcohol concentrations, thus avoiding any ethical and financial issues in obtaining blood specimens. Validation for such screening assessments already exists^{2,3} and as such we advocate the routine use of such questionnaires in the accident department. Screening for blood alcohol concentrations in A&E as a means of identifying at risk drinkers has no role.

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- 1 Carrigan TD, Field H, Illingworth RN, *et al*. Toxicological screening in trauma. *J Accid Emerg Med* 2000;17:33-7.
- 2 Soderstrom CA, Kufera JA, *et al*. Predictive model to identify trauma patients with blood alcohol consumption greater or equal to 50 mg/dl. *J Trauma* 1997;42:67-7.
- 3 Smith SG, Touquet R, Wright S, *et al*. Detection of alcohol misusing patients in A&E departments: the PAT. *J Accid Emerg Med* 1996;13:308-12.

The author's reply

In the discussion of our paper, we highlighted the limitations of toxicological screening in trauma, and acknowledged the role of questionnaires in confirming alcohol (and other drug) misuse or dependence, or both.

Hunt and Rust suggest that questionnaires are as effective as blood alcohol estimation in detecting alcohol intoxication, and blood alcohol estimation has no role in an "accident" department. Questionnaires, in fact, have been shown to be more sensitive and some more specific than blood alcohol estimations for diagnosing alcohol dependence and harmful drinking as compared with the gold standard DSM III-R criteria.^{1,2}

Their referenced paper by Soderstrom indeed predicted certain attributes of presenting patients that could be used to identify alcohol excess and play a part in selective screening in trauma patients, but questionnaires were not validated as such here.³ Soderstrom actually recommends in a subsequent journal edition that blood alcohol estimation, in combination with the CAGE questionnaire, should be used when screening trauma patients.²

Also, a recent article demonstrates the efficacy of brief interventions in decreasing alcohol misuse and most importantly injury recurrence in trauma patients, using blood alcohol estimation and a short questionnaire to identify as many patients as possible for

their randomised controlled trial of an applicable treatment to the emergency department.⁴

The opportunity for questioning may be limited by early discharge, by trauma severity, by cognitive impairment, or by non-compliance. The reliability of questionnaires while the patient is intoxicated or fearful of prosecution is also debatable.

Their other referenced paper, the Paddington Alcohol Test study,⁵ has been shown to be efficacious in a self selecting general emergency population with respect to decreasing alcohol misuse. I thank Hunt and Rust for referencing this paper, as it highlights the major deficiencies of questionnaires in the emergency department, that of poor utilisation by busy staff and variable acceptance by the patient. This must be tackled.

Financially, the marginal cost of a plasma ethanol screen is approximately 50 pence, and ethically, it is a standard test used to identify a cofactor in the altered mental status of a patient in many emergency departments.

In summary, neither brief questionnaires nor blood alcohol estimation are the gold standard in the detection of alcohol misuse or dependence in trauma patients in the emergency department. Rational discussion of such priorities, be it selective screening or the use of toxicological and/or questionnaire screening, needs to take place.

In an ideal department, this should detect as many trauma patients as possible, but should be implemented only if the appropriate referral and brief intervention programmes are concurrent, and these processes evaluated in a cost and outcome effective manner.

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- 1 Cherpitel CJ. Screening for alcohol problems in the emergency room: a rapid alcohol problems screen. *Drug Alcohol Depend* 1995;40:133-7.
- 2 Soderstrom CA, Kufera JA, *et al*. Predictive model to identify trauma patients with blood alcohol consumption greater or equal to 50 mg/dl. *J Trauma* 1997;42:67-73.
- 3 Soderstrom CA, Smith GS, Kufera JA, *et al*. The accuracy of the CAGE, the Brief Michigan Alcoholism screening test, and the Alcohol Use Disorders Identification Test in screening trauma center patients for alcoholism. *J Trauma* 1997;43:962-9.
- 4 Gentilello LM, Rivara FP, Donovan DM, *et al*. Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Ann Surg* 1999;230:473-80.
- 5 Smith SG, Touquet R, Wright S, *et al*. Detection of alcohol misusing patients in accident and emergency departments: the Paddington alcohol test (PAT). *J Accid Emerg Med* 1996;13:308-12.

The Ottawa Ankle Rule

EDITOR,—Further to previous correspondence I think the use of the Ottawa Ankle Rule needs some clarification.¹ Firstly, the Ottawa group^{2,3} themselves acknowledge that clinical judgement should take precedence over sticking to rigid rules. They are also careful to point out several groups in whom they do not feel the rules should be applied, such as the intoxicated, the multiply injured, or those with communication problems either because of language or mental disorder. They are very specific in stating that the entire posterior 6 cm of the malleoli should be palpated (a common error from my observation is just to palpate the tip), and that in the presence of gross swelling this may be impossible to do accurately and therefore a radiograph may be required. I do not believe they recommend

radiography for all patients over 55 years old, but that this is the case for the knee⁴ rather than ankle rules.

Perry *et al*⁵ do not clearly apply the entire rule in their study, and therefore it is difficult to be sure that the four "missed" fractures would definitely not have been picked up if applying it carefully. Nevertheless I think they make a valid point in their conclusions—rules and protocols will not always be right, and experience and clinical judgement are invaluable tools in medicine. The problem we now face is incorporating this notion safely into our evidence-based practice.

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- 1 McCann B. Perspective survey to verify the Ottawa Ankle rules. [Letter and authors' reply]. *J Accid Emerg Med* 2000;17:75-6.
- 2 Stiell IG, Greenberg GH, McKnight RD, *et al*. A study to develop clinical decision rules for the use of radiography in acute ankle injuries. *Ann Emerg Med* 1991;21:384-90.
- 3 Stiell IG, Greenberg GH, McKnight RD, *et al*. Decision rules for the use of radiography in acute ankle injuries: refinement and prospective validation. *JAMA* 1993;269:1127-32.
- 4 Stiell IG, Wells GA, Hoag RH, *et al*. Implementation of the Ottawa Knee Rule for the use of radiography in acute knee injuries. *JAMA* 1997;278:2075-9.
- 5 Perry S, Raby N, Grant PT. Prospective survey to verify the Ottawa Ankle Rules. *J Accid Emerg Med* 1999;16:258-60.

The authors reply

We thank Dr Rae for her interest in our paper on the Ottawa Ankle Rules. The Ottawa Group do acknowledge that clinical judgement should take precedence over adhering to rigid rules. However, they claim a sensitivity of 1:0 if the rules are used and that any missed fractures would not be of clinical significance¹—that is, bone fragments greater than 3 mm in breadth. All four of the missed fractures in our study were significant.² As discussed in the original article, no reason could be found to explain why these cases fulfilled none of the Ottawa Ankle Rules.

We do accept that it was not clearly stated that the entire posterior 6 cm of the malleoli were examined and this may have influenced the study's outcome. However, after retrospective review of the case notes of the four missed fractures we felt that this was not the case.

The Ottawa Ankle Rules were initially devised to include age greater than 55 years as a criterion for radiography.³ Subsequent refinement and validation found age not to be a significant factor.¹ It was included in our study as the aim was to determine if the Ottawa Ankle Rules were valid in a setting of an urban teaching hospital in the United Kingdom.

We accept that there were limitations in our study but feel that it does illustrate the need to be cautious when applying decision rules and that these should not replace clinical judgement and experience.

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- 1 Stiell IG, Greenberg GH, McKnight RD, *et al*. Decision rules for the use of radiography in acute ankle injuries. *JAMA* 1993;269:1127-32.
- 2 Perry SF, Raby N, Grant PT. Prospective survey to verify the Ottawa Ankle Rules. *J Accid Emerg Med* 1999;16:258-60.
- 3 Stiell IG, Greenberg GH, McKnight RD, *et al*. A study to develop clinical decision rules for the use of radiography in acute ankle injuries. *Ann Emerg Med* 1992;21:384-90.

Chest pain observation units

EDITOR.—Goodacre concluded in the January 2000 issue of the journal “there is no strong evidence that chest pain observation units (CPOU) will improve outcomes” and further evidence is necessary to determine whether this approach can be applied in the United Kingdom.¹ He did not reach this conclusion from the cost studies that he listed in table 2. These savings were present in all nine studies reviewed and ranged from \$1873 per patient to \$567 per patient. He reached this conclusion from examination of mortality and missed pathology that he summarised in table 1. The five reviewed studies included three randomised clinical trials.

The flaws in Goodacre’s analysis lies in his failure to examine physician emergency department disposition patterns and his failure to perform power calculations. The missed myocardial infarction (MI) diagnosis rate ranges from 2.8% to 13% in large clinical trials without CPOUs.^{2,5} There is a 11% to 25% death rate for those whose diagnosis is missed and the patient released home from the emergency department with false reassurances.^{2,3} This is the leading cause of adverse outcomes and malpractice suits in emergency medicine in the United States.⁶ The rate of missed diagnosis has been shown to be inversely related to the percentage of emergency department patients receiving a “rule out MI evaluation” (performed during hospital admission before the development of CPOUs).⁵

What sample size is needed to demonstrate a 25% reduction in the missed MI rate? The average miss rate in emergency departments in the United States is 4% with a 60% “rule out MI evaluation” rate.⁵ At this emergency department disposition rate, over 50% of admitted patients are found after full evaluation to have no serious disease as the cause of their symptoms.⁷ The study sample size required to demonstrate a reduction in the average missed MI rate from 4% to 3% is 6262 patients per study arm (85% power). The size of the three randomised clinical trials reviewed by Goodacre were much smaller than this requirement with the largest trial having only 212 patients in each study arm.

I agree with the author’s suggestion to not be complacent with the present traditional emergency department approach to chest pain evaluation. Examination of present United Kingdom utilisation practices (% emergency department patients admitted, % admitted with serious disease) and quantifying the quality of patient care (rigorous follow up to identify the per cent of released emergency department patients with missed disease) might lead the author to reconsideration the value of implementing CPOUs.

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- 1 Goodacre SW. Should we establish chest pain observation units in the UK? A systematic review and critical appraisal of the literature. *J Accid Emerg Med* 2000;17:1–6.
- 2 Goldman L, Cook EF, Brand DA, et al. A computer derived protocol to predict myocardial infarction in emergency department patients with acute chest pain. *N Engl J Med* 1988; 318:797–803.
- 3 Tierney WM, Fitzgerald J, Mchenry R, et al. Physicians’ estimates of the probability of myocardial infarction in emergency room patients with chest pain. *Med Decis Mak* 1986;6: 12–17.

- 4 McCarthy BD, Beshansky JR, D’Agostino RB, et al. Missed diagnoses of acute myocardial infarction in the emergency department: results from a multicenter study. *Ann Emerg Med* 1993;22: 579–82.
- 5 Graff LG, Dallara J, Ross MA, et al. Impact on the care of the emergency department chest pain patient from the Chest Pain Evaluation Registry (CHEPER) study. *Am J Cardiol* 1997;80:563–8.
- 6 Karcz A, Holbrook J, Burke MC, et al. Massachusetts emergency medicine closed malpractice claims:1988–1990. *Ann Emerg Med* 1993; 22:553–9.
- 7 Weingarten SR, Riedinger MS, Conner L, et al. Practice guidelines and reminders to reduce duration of hospital stay for patients with chest pain. *Ann Intern Med* 1994;120:257–63.

Chest pain observation units

EDITOR.—I read with interest Goodacre’s review of chest pain observation unit (CPOU) experience in the United States.¹ While the title raises a critical question “Should we establish chest pain observation units in the UK?” the subsequent review is unable to help us answer this question. This is because the alternatives to CPOU are likely to vary greatly in the two countries. In the United Kingdom many patients judged to be at low risk will be discharged from the accident and emergency department compared with the more common “routine” inpatient observation in the United States. Indeed in the three randomised studies identified, CPOU was compared in Farkouh’s study with monitored cardiology beds and in the studies of Roberts and of Gomez with inpatient telemetry monitoring and hospital admission respectively. This strategy was despite the fact that in the latter two cases the subjects were at “low risk of myocardial infarction”. This definition refers to a less than 7% risk using the computer protocol of Goldman et al.² The conclusion drawn in the abstract is that “there is no strong evidence that a CPOU will improve outcome if routine practice is good” but it would be my contention that it is far from likely that current practice in the UK has been shown so to be.

Unfortunately the title and abstract are what grab the eye and indeed Minerva announces in an ensuing edition of the *British Medical Journal* that “Dedicated units sound like a good idea but there’s little evidence that they save lives or prevent inappropriate discharge.”³

I whole heartedly agree with Goodacre that further studies should be done to determine if CPOU units should be used in the UK.

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- 1 Goodacre SW. Should we establish chest pain observation units in the UK? A systematic review and critical appraisal of the literature. *J Accid Emerg Med* 2000;17:1–6.
- 2 Goldman L, Weinberg M, Weisberg M, et al. A computer-derived protocol to aid in the diagnosis of emergency room patients with acute chest pain. *N Engl J Med* 1982;307:588–96.
- 3 Minerva. *BMJ* 2000;320:524.

The author’s reply

It is true that my conclusion regarding outcomes was not based upon the cost studies listed in table 2. From these studies I concluded that the chest pain observation unit (CPOU) is cost saving in the United States but this may not necessarily be reproduced in the United Kingdom. If the introduction of a CPOU leads to increased rates of referral to coronary care or for angiography, or to CPOU assessment of patients who would otherwise be directly discharged, it is possible that costs

may be increased. Therefore we must either demonstrate that cost savings are reproduced in the UK or demonstrate that a CPOU will improve outcomes.

Examination of emergency department disposition patterns provides a theoretical mechanism by which the CPOU may improve outcomes but does not in itself constitute strong evidence. Historical evidence of missed myocardial infarction can be compared with modern practice in US CPOUs to conclude that they improve such outcomes (reference 5 above) but the limitations of this analysis are discussed in my review.

Had I concluded that “there is strong evidence that the CPOU will not improve outcomes” I would indeed have required a power calculation to assess the possibility of a (false negative) type 2 error. I did not. The distinction is important; lack of evidence of benefit should not be confused with evidence of lack of benefit. It is indeed possible that the CPOU will improve outcomes in the UK but evidence is required.

I share the concerns of both correspondents regarding the quality of acute chest pain assessment in the UK. The conclusions of my review should not be taken as supporting present practice in any way. Indeed, as I stated, descriptive studies show that CPOUs are a safe and practical means of assessing patients with chest pain. No such evidence exists to support our present approach.

Evaluation of the role of the CPOU in the UK will be challenging but offers an excellent opportunity to develop a cost effective, evidence-based service for our patients.

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Three generations of recurrent dislocated shoulders

EDITOR.—A 57 year old man presented with a spontaneous posterior dislocation of his right shoulder. It had happened as he reached up to open an overhead cupboard door. He had first dislocated it eight weeks before, while an inpatient receiving chemotherapy for a brain tumour.

He was accompanied by his daughter. When asked she admitted having dislocated both her shoulders in the past. From the history these seemed to be spontaneous dislocations. As there appeared to be a familial tendency she was asked about other members of the family. One of her three sisters and a niece had also suffered spontaneous dislocated shoulders. She then admitted that the patient was not her biological father: only her stepfather, but that her biological father (deceased) had a history of spontaneous shoulder dislocation. The result of this inquiry was a family tree in which three generations had suffered from spontaneous dislocations of the shoulder. There was no family history of any other joint dislocations, nor was there any history of noticeable joint laxity, or “double jointedness”. None of the family had had any surgery to prevent further recurrences.

Traumatic dislocations of the shoulder are relatively uncommon. Rowe, in 1956, noted that atraumatic shoulder dislocations only accounted for 4% of a series of 500 dislocations.¹ However, atraumatic instability of the shoulder is a well recognised phenomenon, which may be multidirectional and bilateral. Recurrent instability often results from minor

trauma, such as lifting an arm, or reaching up, as described by the index case in this report.

Regarding the familial tendency seen in this case Hovelius noted that 17% of young adults (aged 23–29 years) with shoulder instability had the problem in both shoulders, and that the incidence of dislocation in other family members was 5%, compared with only 1.7% for the general population.² Therefore, the incidence for three generations in a family with dislocating shoulders will be 0.00425% (1.7% × 5% × 5%).

Joint laxity has been suggested as a cause of familial recurrent dislocation of the shoulder.³ It is a feature of several dominantly inherited conditions, such as Ehler's-Danlos and Marfan's syndromes, and osteogenesis imperfecta. Congenital dislocations, especially of the elbow, are also a feature of Larsen's syndrome (pentasomy X). Carter and Sweetnam, who investigated the role of joint laxity in recurrent dislocations of the patella and of the shoulder, found only two families in which two family members had suffered recurrent dislocated shoulders, from their series of 40 patients with recurrent shoulder dislocations.³ In neither case did the condition extend over three generations. A three generation history of recurrent shoulder dislocation would seem to be a very rare event.

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- Rowe C. Prognosis of dislocation of the shoulder. *J Bone Joint Surg* 1956;**38A**:957–77.
- Hovelius L. Anterior dislocation of the shoulder in teen-agers and young adults: Five-year prognosis. *J Bone Joint Surg* 1987;**69A**:393–9.
- Carter C, Sweetnam R. Recurrent dislocation of the patella and of the shoulder. Their association with familial joint laxity. *J Bone Joint Surg* 1960;**42B**:721–9.

BOOK REVIEWS

Too much to read and not enough time: a suggested reading list for accident and emergency specialist registrars

As the specialty of accident and emergency (A&E) develops the knowledge base from which we learn expands. The diversity of the area means it is difficult to provide comprehensive, useful textbooks for the specialty and despite the emergence of a number of handbooks aimed at the senior house officer (SHO) it remains difficult for the specialist registrar to find texts pitched at an appropriate level. The introduction of the FFAEM exam has provided an added impetus for trainees to expand their academic knowledge.

In view of these issues we as a group of A&E trainees in the Yorkshire Deanery have produced a book list that could be used as the basis for specialist registrar reading. We have attempted to cover all areas of A&E practice and, if identified in our search process, include more than one book per subject bearing in mind that doctors from different back-

Reviewers were asked to;
aim for 75–100 words
consider the following:
the relevance of the book to the A&E specialist registrar
its value for money
the books readability and layout
the books scope and quality, rather than just its good and bad points
Are there significant omissions?
Is there discussion of controversial issues?
Are all major points covered?
Is it well referenced?
Is it well illustrated?
Comment on the index/list of contents

Figure 1 Guidelines used as basis of review.

grounds will approach a subject from a different knowledge base. However, some specialties (for example surgery, psychiatry, obstetrics and gynaecology) appear from the search to be poorly catered for in terms of relevance to A&E practice. It may be that individual chapters in the larger A&E texts could be used to fill these apparent gaps in the literature.

We acknowledge the subjectivity of this list and content of each review. We also acknowledge that because of the inevitable delay between compiling and producing these reviews and the time to publication some of the editions included may not be the most current. Where newer editions are known to exist but time did not allow re-appraisal this is documented under the relevant title.

Methods

Over a 10 month period, 25 A&E specialist registrars from the Yorkshire Deanery read and reviewed 72 books. The books were chosen by a number of methods and included those known to the main two authors from their own reading, books available in the three hospital libraries in Leeds in the A&E section and books identified as potentially useful from the local medical bookshop. All A&E trainees and five A&E consultants were also asked to alert us to titles they had found helpful.

The books were reviewed alongside a list of guidelines to try and achieve a degree of objectivity (fig 1). The reviewers were asked to rate the book according to a starring system (fig 2) and those with the highest number of stars included in the list. For completeness we have mentioned those books that were reviewed but did not have the highest number of stars allocated to them.

- ★★★★ pivotal/indispensable — worth ownership
- ★★★ excellent — consider ownership
- ★★ useful for occasional reference — eg, from library or colleagues
- ★ not particularly relevant to the A&E specialist registrar

Figure 2 Starring system to allow comparative rating.

ACCIDENT AND EMERGENCY MEDICINE:
MAJOR TEXTS

Emergency Medicine—Concepts and Clinical Practice. 4th ed. Edited by Peter Rosen, Roger Barkin, Daniel F Danzl, *et al.* (Pp 2930; £182.00.) St Louis: Mosby, 1997. ISBN 0-815-13774-5.

Now in its 4th edition this book continues to lead the field in emergency medicine textbooks. It does not deal with practical procedures but instead serves as an academic reference work covering just about every topic imaginable relevant to current A&E practice. Despite having many authors, the chapters are generally well written and include in depth discussion of controversial aspects where appropriate. The sections on resuscitation, trauma, cardiac emergencies and toxicology are particularly outstanding, whereas the paediatric section is not comprehensive enough. Despite this it is a superb book.

Rating ****

Emergency Medicine: A Comprehensive Study Guide. 4th ed. By Judith E Tintinalli, Ernest Ruiz, Ronald L Krome. (Pp 1472; £110.00) New York: McGraw-Hill, 1997. ISBN 0-070-64879-4.

This is a comprehensive book written predominantly by physicians in emergency medicine. Its relevance to the A&E registrar is not in doubt. The introduction looks at prehospital care and preventative emergency medicine. The layout makes reading easy covering day to day cases and cases of special interest. Regrettably there are no chapter plans, which I feel would have made it easier to read. It covers most emergency topics with no significant omissions. A plus is the chapter on dental problems and the discussion of nerve blocks relevant to the emergency physician. Like most textbooks it fails to reference "statements of fact". It is written for American emergency physicians and as with most American texts there is emphasis on guidelines/protocols and investigations with little credence give to clinical acumen.

Rating ***

(5th edition now available: 1999: ISBN 0-070-65351-8).

Cambridge Textbook of Accident and Emergency Medicine. Edited by David Skinner, Andrew Swain, Rodney Peyton, *et al.* (Pp 1285; £150.75) Cambridge: Cambridge University Press, 1997. ISBN 0-521-43379-7.

This text attempts to introduce A&E medicine as a distinct specialty. The book is divided into three parts. Each chapter has a plan making the book easy to read. Part 2 deals well with "bread and butter" issues found in every A&E department in the UK. There are, unfortunately, some glaring deficiencies such as the omission of subarachnoid haemorrhage. Referencing is rather limited and there are no illustrations in the dermatology section. Compared with the other established emergency medicine textbooks such as Rosen and Barker this book is rather limited. However, it remains the best one written specifically for the UK.

Rating **/***

Also reviewed: Current Emergency Diagnosis & Treatment. 4th ed. Edited by Charles E Saunders and Mary T Ho. (Pp 1015; £39.95). Norwalk: Appleton and Lange, 1992. ISBN 0-838-51347-6 (new ed: 0-838-51469-3).

Rating **

ACCIDENT AND EMERGENCY MEDICINE: MINOR TEXTS

Case Presentations in Accident and Emergency Medicine. By Francis Morris. (Pp192; £15.99). Oxford: Butterworth-Heinemann, 1993. ISBN 0-750-61378-5.

This paperback book in the case presentation series comprises 61 case histories followed by questions regarding differential diagnosis, investigation and treatment options. The answers are succinct and often followed by literature references. The cases cover a wide spectrum of topics ranging from the simple to the more complex, presented in variable order. This book can be recommended as a revision aid for higher A&E exams.

Rating ***

Emergency Medicine Secrets. By Vincent J Markovchick. (Pp 400; £26.95). Pennsylvania: Hanley and Belfus. ISBN 1-560-53051-0.

An excellent teaching and revision aid. It is extremely readable being set out in a question and answer format covering many real life clinical situations. It successfully explores controversies with evidence-based arguments and is helpful in day to day clinical decision making.

Rating ***

Also reviewed: Emergency Medicine. 2nd ed. By Chris Moulton and David Yates. (Pp357; £19.95). Oxford: Blackwell Science, 1999. ISBN 0-632-02766-5.

Rating **

Oxford Handbook of Accident and Emergency Medicine. By Jonathan Wyatt, Robin Illingworth, Mike Clancy, *et al.* (Pp 800; £18.95). Oxford: Oxford University Press, 1998. ISBN 0-192-62751-1.

Rating **

Emergency Triage. By Kevin Mackway-Jones. (Pp 104; £12.95). London: BMJ Publishing Group, 1996. ISBN 0-727-91126-0.

Rating **

Self-assessment in Accident and Emergency Medicine. By Derek Burke, Ian Greaves, and Philip Hormbrey. (Pp 256; £16.99). Oxford: Butterworth-Heinemann, 1996. ISBN 0-750-62215-6.

Rating **

ANAESTHESIA AND INTENSIVE CARE

Clinical Anaesthesia. By Carl L Gwinnutt. (Pp 400; £18.95). Oxford: Blackwell Science, 1996. ISBN 0-865-4249-6.

Written by an anaesthetist with an understanding of the function of A&E this book is a

very useful guidebook for A&E trainees. The anatomy of the book comprises five sections dealing comprehensively with general anaesthesia, local/regional anaesthesia, intensive care, chronic pain and resuscitation. It incorporates basic principles with practical tips and highlights key messages. Each chapter is referenced with suggestions for further reading and illustrations take the form of photographs, flow charts and tables. The downside of the book is its limited chapter on resuscitation but overall it is affordable, relevant and practical.

Rating ***

Anaesthesia and Analgesia in Emergency Medicine. 2nd ed. By Karen A Illingworth and Karen H Simpson. (Pp 406; £24.95). Oxford: Oxford University Press, 1998. ISBN 0-196-2908-5.

A revised edition of the text first published in 1994, this is aimed at A&E staff rather than anaesthetists. It is eminently readable and pitched at an appropriate level for the A&E specialist registrar with no previous anaesthetic experience. It covers local and general anaesthesia, analgesia and sedation. The layout of the first section "General concepts of anaesthesia and analgesia" does not always seem logical. This is somewhat mitigated by a much improved index. It is a pity that similar improvement in the illustrations, particularly in the excellent section on local anaesthesia has not been taken. Despite these reservations it remains a good starting text at a tolerable price.

Rating **/**

Churchill's pocket book of intensive care.

By Simon Whiteley, Andrew Bodenham, Mark C Bellamy. (Pp 298; £16.95). Edinburgh: Churchill Livingstone, 1998. ISBN 0-443-05363-4

This book was indispensable during an intensive care attachment and is an invaluable resource for those of us managing the critically ill patient in the resuscitation area. It is clearly laid out with excellent tables and numerous useful "warning" boxes. The section on optimising the patients haemodynamic status exemplifies the structured approach to the critically ill. There is clear explanation of how to interpret the response to a fluid challenge and of the appropriate use of inotropes and vasoconstrictors. Similarly, topics such as artificial ventilation and invasive monitoring are clearly and succinctly explained. However, the section on the management of the poisoned patient is poor and that of major trauma very brief. Overall this is an excellent pocket manual.

Rating ***

Also reviewed: Intensive Care Medicine.

A Concise Textbook. 2nd ed. By C J Hinds and D Watson. (Pp 447; £32.50). London: Harcourt Brace, 1996. ISBN 0-702-01541-5.

Rating **

Peripheral Nerve Blockade. By C A Pinnock, H B J Fischer, and R P Jones. (Pp 174; £33.50). Edinburgh: Churchill Livingstone, 1996. ISBN 0-443-05064-3.

Rating **

CRITICAL APPRAISAL

Evidence-based Medicine. How to practice and teach EBM. By David L Sackett, W Scott Richardson, William Rosenberg, *et al.* (Pp 256; £14.95). New York: Churchill Livingstone 1997. ISBN 0-443-05686-2.

This is a compact "bible" of EBM. The authors succeed in showing us how to find and use the best clinical evidence, integrate this with our clinical expertise and thus make decisions about patient care. Certain sections of the text are difficult to follow because of, in part, the fact that it assumes more than a basic knowledge of statistics and epidemiology but also because of its self imposed size restraints. Overall it is an excellent introduction into EBM emphasising its clinical application. It is particularly useful for A&E trainees undertaking then FFAEM exam.

Rating ***

(2nd edition is also now available: ISBN 0-443-06240-4. This edition includes a CD.)

The Evidence Based Medicine Workbook. By Robert A Dixon, James F Munro and Paul B Silcocks. (Pp 160; £17.99). Oxford: Butterworth-Heinemann 1997. ISBN 0-750-62590-2.

This book, based on a series of nine research papers, covers both clinical and policy problems in a stepwise fashion. The reader is guided in appraising each paper by answering a series of questions. Although not specifically relevant to A&E the papers allow the authors to demonstrate techniques of appraisal to help the reader make evidence based decisions. A checklist is included at the end of each paper to aid in critical appraisal of other articles the reader may encounter. Dispersed throughout the book are summaries of relevant statistical terms. This book is well presented, easy to read and covers an area of great importance to all of us in training.

Rating **/ ***

How to read a Paper. By Trisha Greenhalgh. (Pp 184; £14.95). London: BMJ Publishing Group, 1997. ISBN 0-727-911392.

A helpful book for understanding the basics of using the medical literature to its full potential. It contains many anecdotal points that bring the concept of evidence based medicine into real life. Included are excellent chapters on the use of Medline and medical statistics and structured advice on how to appraise papers about diagnostic tests, systematic reviews, guidelines and qualitative research. The checklists in the appendix for each section of the book are useful for quick reference. Excerpts from this book have appeared in a BMJ series in 1997.

Rating **/ ***

DERMATOLOGY

Lecture Notes in Dermatology. 7th ed. By R Graham-Brown and T Burns. (Pp 298; £14.95). Oxford: Blackwell Science, 1996. ISBN 0-865-42635-X.

This book is both concise and relevant the A&E specialist registrar. Well laid out with many excellent illustrations and clinical photographs it covers the spectrum of dermatology from commonly encountered problems to

more esoteric conditions. As expected in such a short book it does not focus greatly on controversial issues. Unfortunately there are no references or suggestions for further reading. This is excellent value and overall an excellent book.

Rating ***

Also reviewed: ABC of Dermatology. 3rd ed. By P K Buxton. (Pp120; £17.95). London: BMJ Publishing Group. ISBN 0-727-91150-3.

Rating **

Clinical Dermatology. 4th ed. By Rona M MacKie. (Pp 334; £19.95). Oxford: Oxford University Press, 1996. ISBN 0-192-62761.

Rating **

ENT

ABC of Otolaryngology. 4th ed. By Harold Ludman. (Pp 72; £15.95). London: BMJ Publishing Group, 1997. ISBN 0-727-91205-4.

This offers a concise overview of ENT for the non-specialist. It is arranged into short chapters, each of which focuses on a presenting complaint rather than a disease, with helpful advice on the management of each area. It is aimed at general practitioners but has much to commend it to A&E trainees as the conditions described make up a substantial proportion of ENT cases seen in our departments. The book is not particularly detailed and trainees wanting a more in depth review of an ENT topic would be well advised to consult more substantial texts. The chapter on injuries is particularly short and trauma to the larynx not covered at all.

Rating ***

Also reviewed: Clinical ENT—an illustrated textbook. By Gerald M O'Donoghue, Grant J Bates and Antony A Narula. (Pp 234; £18.95). Oxford: Oxford University Press, 1992. ISBN 0-192-61667-6.

Rating **

GYNAECOLOGY AND OBSTETRICS

Emergencies in Obstetrics and Gynaecology. By Lindsey Stevens and Anthony Kenny. (Pp 276; £14.95). Oxford: Oxford University Press, 1994. ISBN 0-192-62051-7.

A significant amount of the A&E workload falls into this category and as such it is a relevant topic. However, this publication is badly organised and in parts long winded.

Much, if not all, the relevant information is contained but it is difficult to pinpoint. Reference lists are included but I do not feel this book offers value for money. I can recommend this book only in the absence of a suitable alternative.

Rating **

LEGAL AND FORENSIC MEDICINE

Legal Problems in Emergency Medicine. By Alan Montague. (Pp 176; £16.95). Oxford: Oxford University Press, 1996. ISBN 0-192-62496-2.

Like most of the Oxford series, this book is affordable and well referenced. The text is a

relevant blend of legal principles and practical clinical advice on a variety of subjects, including departmental discipline, consent and confidentiality and court attendance. Case reports complement and clarify the legal principles discussed. The reference section discusses the legal issues relating to the police, controlled drugs and the mentally ill. Written by someone who has sat on both sides of the fence, so to speak, it is essential reading for the specialist registrar and consultant.

Rating ***

Also reviewed: Legal Aspects of Medical Practice. 5th ed. By Bernard Knight. (Pp 386; £22.00). Edinburgh: Churchill Livingstone, 1992. ISBN 0-443-04568-2.

Rating **/***

MANAGEMENT

Health and Social Care Management: a guide to self-development. By Sara Whiteley, Richard Ellis and Sinclair Broomfield. (Pp 230; £15.99). London: Arnold, 1996. ISBN 0-340-61411-0.

Managerial issues represent an important aspect of an A&E consultant's workload and as such form an integral part of the FFAEM exam. This book outlines the management skills needed by a practising medical manager and I found the contents to be comprehensive. Each chapter uses a case study to illustrate particular issues. The style of the book is easy to read and each chapter contains several references in order to expand on important topics. This is a valuable introduction to medical management.

Rating ****

Also reviewed: Clinical Risk Management. Edited by Charles Vincent. (Pp 588, £35.00). London: BMJ Publishing Group, 1996. ISBN 0-727-90947-9.

Rating **

MAXILLOFACIAL EMERGENCIES

Maxillofacial and Dental Emergencies. By John Hawkesford and James G Banks. (Pp 192; £24.95). Oxford: Oxford University Press, 1994. ISBN 0-192-61997-7.

This book, written by a maxillofacial surgeon and an A&E consultant, covers a subject of great relevance to specialist registrars in A&E. It is easy to read, has a user friendly layout and contains a large amount of useful information. However, it is often difficult to pick out the important facts from others of less relevance, such as anatomical descriptions and details of surgical operations. The text is accompanied by many useful illustrations including radiographic examples. No reference lists are provided although additional reading is recommended after certain chapters. Despite the deficiencies in this book I have improved my knowledge by reading it. I could not however recommend ownership.

Rating **

Craniofacial Trauma. An interdisciplinary approach. By N Jones. (Pp 224; £25). Oxford: Oxford University Press, 1997. ISBN 0-192-62856-9.

Craniofacial trauma management is often a multidisciplinary event. With this in mind,

the authors have written a reference book providing an integrated strategy for its management. After an excellent chapter summarising the initial ATLS approach to the patient, subsequent chapters follow in "ABC" sequence. Probably the most surprising chapter is the last one—"Talking to relatives". In just over one side, this chapter conveys more useful information than larger chapters in more substantive texts. The authors have certainly achieved their objective of producing an excellent multidisciplinary text. It is highly readable and delivers an excellent insight into the ongoing management of these patients.

Rating **

MEDICINE

Oxford Handbook of Acute Medicine. By Punit S Ramrakha and Kevin P Moore. (Pp 892; £16.95). Oxford: Oxford University Press, 1997. ISBN 0-192-62682-5.

This concise text provides structured information on the diagnosis and management of medical emergencies. All systems are covered from cardiovascular to dermatological problems and there are useful additional chapters on shock, pharmacology of emergency drugs, environmental emergencies and practical procedures. Considering the size of this book it contains an amazing amount of detail but this is often in list format. It is probably best used for quick reference in the department or for review of a problem after it has occurred rather than for comprehensive easy reading.

Rating ***

Advanced Cardiac Life Support: the practical approach. 2nd ed. Edited by Peter Driscoll, Carl Gwinnutt, Kevin Mackway-Jones, *et al.* (Pp 260, £24.99). London: Chapman and Hall. ISBN 0-412-71090-0.

Written for a "broadly based affiliation of health care professionals" this text is clear and easily readable with good quality illustrations to aid understanding. As well as basic and advanced life support in adults the book covers resuscitation in children and special circumstances, acid-base homeostasis, procedures used in resuscitation and the ethical aspects of resuscitation. The algorithms are current. There is little in this book that is not covered in the ALS/PALS/APLS courses but topics are dealt with in greater detail than the manual of the adult course. Paediatric resuscitation would be better dealt with in a separate book.

Rating ***

Also reviewed: ECG Interpretation for emergency medicine—a self assessment guide. By F Morris, RC Jenkins, J M Ahmed, *et al.* (Pp 160; £14.99). Oxford: Butterworth-Heinemann, 1998. ISBN 0-750-63019-1.

Rating **

Acute Medical Emergencies. By U Guly and D Richardson. (Pp232; £16.95). Oxford: Oxford University Press, 1996. ISBN 0-192-62558-6.

Rating */**

Cardiac Arrhythmias. Practical notes on interpretation and treatment. 5th ed. By D H Bennett. (Pp 245; £16.95). Oxford: Butterworth-Heinemann, 1997. ISBN 0-750-63369-7.

Rating */**

OPHTHALMOLOGY

Lecture notes on Ophthalmology. 8th ed. By B James, C Chew and A Bron. (Pp 208; £13.95). Oxford: Blackwell Scientific, 1996. ISBN 0-865-42723-2.

This overview of ophthalmology contains information that is of use to the A&E registrar as well as that which could be considered superfluous. Sections on anatomy and physiology serve as revision and a description of eye examination allows a structured approach to the patient's problem. Chapters are arranged by pathology or structure rather than by symptom so there is little to help us differentiate between the causes of the "red eye" so commonly encountered. Although management of then conditions is described I was unable to elicit when expert help is appropriate. There are many detailed illustrations but relatively few photographs for such a visual specialty.

Rating **

Also reviewed: ABC of Eyes. 2nd ed. By P T Khaw and A R Elkington. (Pp 68; £14.95). London: BMJ, 1994. ISBN 0-727-90766-2.

Rating */**

(3rd edition now available: ISBN 0-729-1436-7).

ORTHOPAEDICS AND TRAUMA

Pocket Book of Orthopaedics and Fractures. By Ronald McRae. (Pp 520; £15.95). Edinburgh: Churchill Livingstone, 1999. ISBN 0-443-05952-7.

McRae's latest addition to his collection of orthopaedic manuals is a concise pocketbook, ideally sized for quick reference in the A&E department. It covers all the aspects of orthopaedic examination and fracture management relevant to the A&E doctor. Unfortunately I found the layout slightly cramped and, as with most texts, the radiographs often difficult to interpret on paper. Worthy of mention are the lists of pitfalls of commonly missed fractures and the hints on assessing functional overlay in back pain. In summary it would be an affordable and extremely useful quick reference book for the A&E doctor.

Rating ****

Emergent Management of Trauma. By Thomas A Scaletta and Jeffrey J Schaidler. (Pp 520; £26.99). New York: McGraw-Hill, 1996. ISBN 0-070-57238-0.

This book delivers concise points of valued information on all aspects of trauma from pathophysiology to patient management and disposition. Reasonably priced and readable, the practical sections on anatomical areas of injury help to consolidate knowledge and aid in informed trauma assessment. There are also relevant sections on resuscitation concepts, radiography, procedural techniques and environmental emergencies. It was pleasing to note that when disposition was discussed referral criteria to specialist centres are

defined. A North American text, it loses a little in translation but is applicable to European emergency practice.

Rating ***

The Management of Head Injuries. A Practical Guide for the Emergency Room. 2nd ed. By David Currie. (Pp 206; £26.95). Oxford: Oxford University Press, 2000. ISBN 0-192-63078-4.

Although no direct reference is made to this book's previous incarnation as volume 5 in the Oxford Handbooks in Emergency Medicine series it will be familiar to many. It is a slim, elegantly presented, highly readable and possibly overpriced introduction to a subject that may soon have even more relevance to A&E specialists. Several typographical errors are apparent, some radiographs reproduce poorly and a few contradictions exist within the text (presumably a result of not all the text being updated since the first edition) but on the whole an informative, valuable addition to the departmental, and possibly personal, library.

Rating ***

Also reviewed: Practical Fracture Treatment. 3rd ed. By Ronald McRae. (Pp 389; £30.50). Edinburgh: Churchill Livingstone, 1994. ISBN 0-443-04809-6.

Rating **

Clinical Orthopaedic Examination. 4th ed. By Ronald McCrae. (Pp 308; £22.00). Edinburgh: Harcourt Brace, 1997. ISBN 0-443-05602-1.

Rating **

ABC of Major Trauma. 2nd ed. Edited by David Skinner, Peter Driscoll and Richard Earlam. (Pp 140; £16.95). London: BMJ Publishing Group, 1996. ISBN 0-727-90917-7.

Rating **

(3rd edition now available: ISBN 0-727-91378-6).

ABC of Spinal Cord Injury. By David Grundy and Andrew Swain. (Pp 80; £13.95). London: BMJ Publishing Group, 1996. ISBN 0-727-91049-3.

Rating **

Emergency Orthopaedics and Trauma. By Andrew Unwin and Kirsten Jones. (Pp 272; £25.00). Oxford: Butterworth Heinman, 1995. ISBN 0-750-62034-X.

Rating **

Major Incident Medical Management and Support. The Practical Approach. Edited by T J Hodgetts and K Mackway-Jones. (Pp 205; £25.00). London: BMJ Publishing Group, 1995. ISBN 0-727-90928-2.

Rating **

Trauma. By I Greaves, J M Ryan and K M Porter. (Pp 448; £47.50). London: Hodder and Stoughton, 1998. ISBN 0-340-69201-4.

Rating *

Trauma Resuscitation—The team approach. By P A Driscoll, C L Gwinnett, C Leduc Jimmerson, *et al.* (Pp 458; £30.00). Basingstoke: Macmillan, 1993. ISBN 0-333-54538-9.

Rating *

PREHOSPITAL CARE

Handbook of Immediate Medical Care. By Ian Greaves, Peter Dyer, Keith Porter. (Pp 384; £18.95). London: Harcourt Brace, 1995. ISBN 0-702-018813.

This is a concise guide for those working in emergency medicine with an interest in prehospital care, and a useful revision text for the Diploma in Immediate Care.

Covering a wide range of common emergencies as well as rarer events such as psychiatric, obstetric and chemical incident emergencies. Clear tables and line diagrams are helpful for quick referral. References are mostly to larger textbooks and commonly used guidelines. The useful appendix covers equipment, BASICS, radio communications and triage exercises. It is a cheap, practical handbook with many chapters useful for uncommon emergencies in the A&E department.

Rating ***

Also reviewed: Pre-hospital Medicine. The principles and practice of immediate care. Edited by Ian Greaves and Keith M Porter. (Pp 800; £145.00). London: Hodder and Stoughton, 1999. ISBN 0-340-67656-6.

Rating **/**

Pre-Hospital Emergency Management Master. By Tim Hodgetts. (Pp 72; £35.00). London: BMJ Publishing Group, 1995. ISBN 0-727-90905-3.

Rating **

Prehospital Trauma Life Support. 3rd ed. By National Association of Emergency Medical Technicians. (Pp 416; £30.00). St Louis: Mosby International, 1994. ISBN 0-815-16333-9.

Rating *

PAEDIATRICS

Advanced Paediatric Life Support. The Practical Approach. 2nd ed. By the Advanced Life Support Group. (Pp 320; £25.00). London: BMJ Publishing Group, 1997. ISBN 0-727-91069-8.

This will certainly go some way toward improving the A&E management of paediatric emergencies. There are good sections on respiratory emergencies, shock and cardiac arrest with weaker sections on poisoning, radiology and bereavement; no paediatric resuscitation chart is included. Easy to read and good value for money. The "practical approach" is more apparent on the APLS course and the manual is best used in conjunction with this. A major development would be the provision of a pocket sized formulary of drugs used in paediatric emergencies for day to day convenience. No references are included although suggested reading lists are.

Rating ****

Paediatric Emergency Medicine; a comprehensive study guide. (The American College of Emergency Physicians). By Gary R Strange and William Ahrens. (Pp 768; £54.99). New York: McGraw-Hill. ISBN 0-070-62007-5.

This is a comprehensive textbook dealing with all aspects of the child in the emergency department. It is divided into sections detailing resuscitation, trauma care and various system emergencies. Each section is then subdivided into short readable chapters. The style is clear and informative and provides a basic overview of most conditions although by necessity some of these chapters are somewhat repetitive and there is little discussion of controversies. There are a few illustrations although this is not a book for algorithm lovers. Overall I think this represents value for money and is a useful general text.

Rating ***

ABC of Child Abuse. 3rd ed. Edited by Roy Meadow. (Pp 96; £15.95). London: BMJ Publishing Group, 1997. ISBN 0-727-91106-6.

This represents good value for money. It highlights areas many of us overlook or not recognise for what they are. It is well structured and receives contributions from all disciplines relevant to the subject—that is, lawyers, doctors, social services, psychologists. There is a reasonable range of relevant illustrations in a limited space. It is well referenced. This book would, however, be well supplemented by an atlas of child abuse. Appropriate courses of action and legal aspects are set out clearly.

Rating ****

Also reviewed: Accidents and Emergencies in Children. 2nd ed. By Rosemary J Morton and Barbara M Phillips. (Pp 282; £16.95). Oxford: Oxford University Press 1996. ISBN 0-192-62719-8.

Rating ***

The Management of Injuries in Children. By John F T Glasgow and H Kerr Graham. (Pp 300; £35.00). London: BMJ Publishing Group, 1997. ISBN 0-727-90925-8.

Rating ***

Physical Signs of Child Abuse. By Christopher J Hobbs and Jane M Wynne. (Pp 256; £66.00). London: Harcourt Brace, 1996. ISBN 0-702-01778-7.

Rating **

What to do in a Paediatric Emergency. By Ian Higginson, David Montgommery, Phil Munroe. (Pp 60; £12.95). London: BMJ Publishing Group, 1996. ISBN 0-727-91032-9.

Rating *

PSYCHIATRY

Psychiatric Emergencies. By Stephen Merson and David Baldwin. (Pp 134; £12.95). Oxford: Oxford University Press, 1995. ISBN 0-192-62477-6.

Written in the familiar Oxford text style, this is an affordable but brief overview of psychiatric

emergencies. The sections on the practical issues, such as treatment refusal and the emergency use of the Mental Health Act, allow for educated liaison with the psychiatric services. It gives advice on the appropriate management of common psychiatric emergencies but it would benefit from having a more readable and practical discussion on mental state assessment.

Rating **

RADIOLOGY

Accident and Emergency Radiology—A Survival Guide. By N Raby, L Berman, and G de Lacey. (Pp 264; £17.95). London: Harcourt Brace, 1994. ISBN 0-702-01905-4. This book should have a place on every A&E SpR's bookshelf, particularly those who have little previous orthopaedic experience. Each chapter follows the same pattern of essential radiographs, review of the relevant anatomy, an illustration of normal variants and abnormalities and finally a summary of key points. The illustrations are easily understood and well labelled. It devotes more space to illustrations than to text, and focuses on areas of difficulty and frequently missed injuries.

Rating ***

Also reviewed: ABC of Emergency Radiology. Edited D A Nicholson and P A Driscoll. (Pp 100; £16.95). London: BMJ Publishing Group, 1995. ISBN 0-727-90832-4.

Rating **/**

STATISTICS AND RESEARCH

Statistics in Clinical Practice. By David Coggon. (Pp120; £10.95). London: BMJ, 1995. ISBN 0-727-90907-X.

Aimed at doctors who view statistics as a necessary evil this reassuringly thin volume does not contain vast swathes of unfathomable algebra. It makes easy reading and is divided into eight chapters covering the basics of statistics. These include types of data, how to summarise data, probability, hypothesis testing and power and sample size estimation. Each chapter includes examples to allow ease of understanding followed by questions to test the knowledge acquired. It is lacking in detail on specific statistical tests and will not allow the reader to choose a test to apply to their own data. It does cover most areas required by an A&E trainee to allow sensible interpretation of the statistics in most scientific papers.

Rating ***

Also reviewed: How to write a paper. Edited by George M Hall. (Pp 128; £11.95). London: BMJ Publishing Group, 1994. ISBN 0-727-90822-7.

Rating ***

Medical Statistics—a commonsense approach. 2nd ed. By M J Campbell and D Machin. (Pp 200; £16.99). Chichester: Wiley, 1993. ISBN 0-471-93764-9.

Rating ***

SPORTS INJURIES

Sports Injuries: Recognition and Management. 2nd ed. Edited by M A Hutson. (Pp 246; £29.95). Oxford: Oxford University Press, 1996. ISBN 0-192-62675-2.

This text is aimed at the medical practitioner who may encounter sports injuries as part of his daily practice. It covers applied anatomy, examination biomechanics and regional injuries as well as prevention of injury, rehabilitation and treatment. It covers soft tissue injuries well but the inadequate coverage on bony injuries mean this would have been better left to more specialised texts. It is easy to read but the photos appear rather dated and give the book an older feel than it really is.

Rating **/**

Also reviewed: ABC of Sports Medicine. 2nd ed. G McLatchie, Mark Harries, C Williams, J King. (Pp 128; £18.95). London: BMJ Publishing Group, 1999. ISBN 0-727-91366-2.

Rating **

TOXICOLOGY

Acute Poisoning. Diagnosis and Management. 2nd ed. By A T Proudfoot. (Pp 304; £22.50). Oxford: Butterworth Heinmann 1993. ISBN 0-750-61455-5.

This is a good general text on poisoning. It covers the basic management of the poisoned patient in an easy to follow manner emphasising the importance of "ABC". However, it does seem dated in its discussion of emesis as a method of gastric decontamination. It proceeds to take the reader through an alphabetical list of drugs (both medical and illicit), common industrial agents, plants and animals, which may cause poisoning giving concise information on the general and specific clinical features, the management and the prognosis for each agent. As a reference for looking up specific poisons the layout is user friendly but not so stimulating as a straight read.

Rating **

Also reviewed: Paediatric Toxicology: a hand book of poisoning in children. By N Bates, N Edwards, J Roper, *et al.* (Pp 352; £59.00). London: Macmillan, 1997. ISBN 0-333-60951-4.

Rating *** (but more specialised than may be required).

WOUNDS

Wounds and Lacerations: Emergency care and closure. 2nd ed. By Alexander T Trott. (Pp 384; £37.00). St Louis: Mosby, 1997. ISBN 0-815-18853-6.

For those starting A&E higher training from a more medical background, this is a useful book on a neglected area. Its strengths are that it is very readable and has excellent illustrations. There are useful chapters on advanced suturing techniques, peripheral nerve blockade and paediatric sedation. The book is well referenced but could have been improved by the inclusion of more advanced techniques such as finger-tip v-y plasty and extensor

tendon suturing, and surprisingly, pretibial laceration is hardly mentioned. The high price is a drawback.

Rating **/***

Also reviewed: *The Management of Wounds and Burns*. 2nd ed. By Jim Wardrope and June Edhouse. (Pp 256; £24.95). Oxford: Oxford University Press, 1999. ISBN 0-192-62999-9.

Rating **

Conclusion

Although there are many other books that have not been included in our review process, either because they were not identified in our search process or because they have been published since this project was completed, we hope this serves as a starting point for the A&E specialist registrar baffled by the volume of available literature.

The financial implications of owning such a library are not to be minimised. Many will be available from the hospital library, departmental library or even from the office of the consultants so we do suggest looking for them locally.

It is worth noting that although there is an overlap this list is intended to be different from one for an A&E department library, which by its nature is designed for use by doctors at all levels of training as well as for nurses or paramedical staff.

Happy reading!

Contributors

Helen Law initiated and coordinated the review process, defined the review criteria, constructed the paper, edited the reviews and contributed to the reviews and acts as guarantor. Francis Andrews initiated and assisted in the coordination of the review process, defined the review criteria, applied the search

strategy to identify the books and contributed to the reviews. The following also undertook the book reviews; Jane Brenchley, Stephen Bush, Jim Butler, Thomas Carrigan, Steven Crane, Gaynor E Creaby, Meg Crossley, Charlotte Doughty, Paul Gaffney, Rob Halstead, Jonathan Jones, Melanie Kavanagh, Adrian Kerner, Gary T Kitching, Andrew S Lockey, Richard Lynch, Amjid Mohammed, Chikezie Dean Okereke, Kirsten Jane Campbell Richards, Jed Selvakumar, M M S Tan, A Taylor, Alison Walker.

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ABSTRACT

The following was omitted from the abstracts published in the November 2000 issue of the journal for the Millennium Scientific Meeting hosted by the Faculty of Accident and Emergency Medicine

The ethics of war and police—do 21st century bullets meet 19th century ideals?

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Introduction—Explosive, expanding and fragmenting bullets were all outlawed by a series of international conventions during the 19th century, the last of which was the Hague Convention in 1899. Although these inter-

national agreements effectively ensured that all military bullets in the 20th century were fully jacketed (to prevent fragmentation and “unnecessary suffering”), they have never applied to bullets used in civilian law enforcement.

Objective—To examine the wounding potential of 12 types of modern military and police small arms ammunition and to review the ethics of their use.

Methods—Fully jacketed and hollow point versions of 5.56 mm, 7.62 mm, 0.338” and 9 mm ammunition were tested against 15 cm × 15 cm × 30 cm blocks of ballistic gelatin, prepared in accordance with standardised methods. Additionally, we tested 0.357”, 0.40” and 0.45” hollow point, and unjacketed 10 mm lead ammunition for comparison. Rifle rounds were tested at 100 m and pistol rounds at 6 m.

Results—For high energy rifle bullets (5.56 mm, 7.62 mm and 0.338”) there was little difference in wound profile between fully jacketed (FMJ) and hollow point (HP) bullets. Nine mm FMJ and 10 mm unjacketed lead pistol bullets produced classical straight wound tracks with little evidence of damage outside the immediate bullet path. Nine mm HP, 0.357 HP, 0.40” HP and 0.45” HP bullets all showed minor cavitation effects immediately after penetration of the blocks, and many lead core fragments were seen in the track of the 0.40” bullet.

Conclusions—Modern rifle ammunition has extremely high energy and in practical terms, full metal jacketing or modification of the bullet point is probably irrelevant to wounding potential. Our tests and clinical case reports indicate that even FMJ ammunition is prone to fragmentation. Lower energy hollow point pistol ammunition, however, does produce some cavitation effects that have not been previously widely reported, and jacketing does influence bullet behaviour.