LETTERS TO THE EDITOR

Fireworks related injuries: does changing legislation make a difference? A thought for next Hallowe’en

EDITOR,—In August 1996 there was a change in legislation. The Explosives Act (Northern Ireland) 1970 (as amended by the Explosives (Amendment) (Northern Ireland) Order 1996) allowed over the counter sale of fireworks to anybody over 16 year of age.1 Prior to this, it was illegal to buy fireworks in Northern Ireland. For the same four week period (11 October–11 November) for the years 1994 and 1995, all accident and emergency notes were reviewed retrospectively and patients with firework related injuries were identified. The years 1996–1998 were collected prospectively. The patients’ age, sex, date of presentation, injury, site of injury and follow up were recorded.

Thirty five patients presented to the department with fireworks related injuries over the study period. This consisted of 27 men and eight women (fig 1). Men in their late teens (mean age 18 years, 77% of all males) were the predominant group. Fifty five per cent of all injuries involved the hand.

There has been a threefold increase in the number of injuries presenting to this department after the change in legislation ($\chi^2 = 20.61, p<0.001$).

In this hospital, firework injuries presented most commonly on Hallowe’en night (31 October) and the following night (fig 2). This is due to the people of Londonderry celebrating “the biggest Hallowe’en party in Europe”. This peak is not reflected in national figures as the trend is for the injuries to occur around the 5th of November (Guy Fawkes night).3 With this in mind, campaigns should run to target periods that are identified locally.

Firework injuries in Northern Ireland are not included in the national yearly figures published by the Department of Trade and Industry (DTI).2 Firework injury reporting has only been monitored in Northern Ireland since 1996, but the figures are collected and sent yearly to the DTI.

Legalisation of the sale of fireworks has resulted in an increase in the number of fireworks related incidents. This is not in keeping with the trends noted in Great Britain. Northern Ireland firework injury figures, albeit collected, are not included in the national reported figures.

J J JOHNSTON
M JENKINS
L A MCKINNEY
Altnagelvin Area Hospital,
Glenshane Road,
Londonderry BT47 6SB,
Northern Ireland

1 The Explosives (Amendment) (Northern Ireland) Order 1996.
3 Survey of the use of rapid sequence induction in the accident and emergency department

EDITOR,—The paper by Walker and Brenchley highlights a crucial area of emergency medicine practice. The key issues are “How are skills maintained” and “What is an acceptable period of training”.

The authors state in their conclusions that the majority of accident and emergency (A&E) consultants thought that rapid sequence induction (RSI) would be undertaken by A&E staff if an anaesthetist was unavailable. If the A&E staff are only performing this procedure rarely then they will become de-skilled and will have a higher complication rate than a colleague performing the procedure on a regular basis. Anaesthesia is defined as an essential secondment for training, why is this secondment if the skills are not going to be actively used.

In order to give the responsibility of “on call” the anaesthesia minimum requirement is three months of supervised training. I feel that it is no coincidence that this also is the length of our secondment.

KELVIN D WRIGHT
Accident and Emergency Medicine, Wycombe General Hospital, Queen Alexandra Road, High Wycombe HP11 2TT, UK (Kwilght@doctors.org.uk)

1 Survey of the use of rapid sequence induction in the accident and emergency department.

EDITOR,—As a doctor with a background in both anaesthesia and accident and emergency (A&E) medicine, and currently working in an emergency medicine environment, I read the paper by Walker and Brenchley with interest.1 I have been aware for some time now of the debate among emergency physicians, and anaesthetists, over their respective roles in emergency airway management. I suspect that anaesthetists are probably guilty of being of blindly territorial, and somewhat condescending, over the issue. However, I am also aware that among emergency physicians there is a slightly concerning “gung-ho” element to their approach to this procedure, which I believe betrays a lack of understanding of the technique, and of the risks involved. In illustration of this, I remember seeing in an A&E department of a hospital I have worked in, the abbreviation RSI expanded to “rapid sequence intubation”.

The use of RSI of anaesthesia to facilitate intubation of the trachea is an inherently risky technique. So that the risk of regurgitation and aspiration is minimised, the patient is paralysed before control of the airway is assured. Furthermore, unlike in any other anaesthetic technique, the drugs used are given as a rapid bolus of a predetermined dose. These agents have real potential for causing harm and a thorough understanding of their actions is necessary to appropriately tailor the choice, and dose, of drugs used. While I accept that in most cases the technique is safe and effective, and that the complication rate is low, I would suggest that the risk of problems, serious problems, remains real. It requires not only training (such as the Advance Airway Course), but also experience (such as an anaesthetic attachment and supervised emergency intubations) in order to anticipate, and avoid, these problems, and to be able to safely retrieve any difficult situations that can be encountered despite this.

It is this need for experience gained in practice that would seem to pose the major problem in UK emergency departments. The number of cases in the UK where drugs are required to facilitate “immediate airway protection” must be comparatively low and these cases are conceded to be the most testing, even for experienced anaesthetists.4 Addition- ally in the more common cases where airway protection is less urgent, and where subsequent management is likely to be the responsibility of the anaesthetists or ITU staff, it would seem appropriate that the team delivering definitive care is involved from the outset. Opportunity, therefore, for any individual A&E physician to practise and maintain the skills they have been trained in would inevitably be infrequent. When faced with a case requiring RSI even the most junior of on call anaesthetists is likely to have practised the technique more recently.

With all of this in mind I would still maintain that there probably is a place for A&E physicians taking on airway management in the UK. However, I feel this process must be approached with respect for the technique and a grasp of the need for practice and experience. Similarly anaesthetists should welcome this desire to share the responsibility for the “head end”, should not seek to unnecessarily shroud their art in myst- ery, and rather offer to facilitate the acquisition and maintenance of these skills.

ANDREW J CADAMY
Cio P&O Cruises (UK) Medical Department, Richmond House, Terminus Terrace, Southampton PO14 3PN, UK (ajcadamy@compuserve.com)

1 Survey of the use of rapid sequence induction in the accident and emergency department.

EDITOR,—I read with interest the article by Walker and Brenchley regarding the use of RSI by accident and emergency (A&E) medici- cal staff.1 Emergency medicine is characterised by the ABC approach with airway management as the first priority, which by definition includes performing RSI where necessary. Thus it is essential that A&E staff can do this competently and completely. Regular and routine practice of RSI will help prevent skill deterioration as will the use of patient simulators for airway training as described by Ellis and Hughes.2 Hence, A&E...
Letters to the editor

Stewart MCMorran
Department of Accident and Emergency Medicine, Northampton General Hospital
Correspondence to: Dr McMorrman, Milton Keynes General Hospital, Standing Way, Milton Keynes, Buckinghamshire MK6 5LD (stewart.mcmorrman@btinternet.com)


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The Resuscitation Council (UK) however, recommend that calcium chloride 10% be used in the treatment of electromechanical dissociation attributable to hyperkalaemia. I am aware the impression that calcium chloride is preferable to calcium gluconate, the treatment of hyperkalaemia on account of its greater bioavailability.

Eric D. O'Donnell
Department of Accident and Emergency Medicine, Northampton General Hospital
Correspondence to: Professor E. O'Donnell, Department of Accident and Emergency Medicine, Northampton General Hospital, Lillicrap Road, Northampton NN5 6UA

Rapid defibrillation: welcome, but sometimes a false sense of security

Letters to the editor

Stewart Kimble
Department of Accident and Emergency Medicine, Southend General Hospital
Correspondence to: Dr Kimble, Southend General Hospital, Southend-on-Sea, Essex SS0 7TY, UK

The treatment of hyperkalaemia in the emergency department

Stewart MCMorran
Department of Accident and Emergency Medicine, Northampton General Hospital
Correspondence to: Dr McMorrman, Milton Keynes General Hospital, Standing Way, Milton Keynes, Buckinghamshire MK6 5LD (stewart.mcmorrman@btinternet.com)


Clearing the cervical spine in the unconscious trauma patient

Mike Clancy
Consultant in Accident and Emergency Medicine, Royal Infirmary, Great George Street, Leeds LS1 3EX, UK

Clearing the cervical spine in the unconscious trauma patient

We agree with the comments made by Wright and White.

Cadamy notes that training and experience are essential. Part of the programme to introduce these skills in A&E would obviously include both inhouse training and courses such as the Advanced Airway Course, which is being introduced into the UK. We would suggest that emergency physicians should routinely undertake airway resuscitation in the department to maintain skills. Only attempting RSI of patients "in extremis" is clearly a recipe for disaster.

Trained assistance is obviously the ideal, but may not always be available for the same reasons as anaesthetic help is not immediately accessible in all circumstances. There may be scope to train A&E nurses in these basic skills.

A WALKER J BRENCHLEY Accident and Emergency Department, Leeds General Infirmary, Great George Street, Leeds LS1 3EX, UK

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Intranasal midazolam. An alternative in childhood seizures

EDITOR.—The fitting child is a common problem presenting to the emergency department. Prolonged fitting is potentially harmful and early treatment of seizures may reduce actual mortality and morbidity. The gold standard against which new treatments have to be compared has been rectal diazepam or intravenous lorazepam.

Obtaining intravenous access in a fitting child can be difficult. The rectal route has been shown to be both in hospital and before hospital admission. There are however difficulties with this route: absorption may be variable and non-medical staff may be reluctant to administer rectal drugs. Recently interest has been shown in the use of midazolam administered via the buccal route to treat fits in the prehospital environment. It was shown to be efficacious and safe though no significant reduction in time to seizure cessation was found in comparison with rectal diazepam. A further trial set in an emergency department compared intranasal midazolam (0.2 mg/kg) with intravenous diazepam. Time to seizure control from admission was found to be less in the midazolam group.

Midazolam via the intranasal route has been successfully used for pre-procedural sedation of children and has confirmed anti-epileptic properties. Indeed EEG evidence of antiepileptic effects has been demonstrated.

We have successfully used intranasal midazolam on two fitting paediatric patients who proved difficult to obtain intravenous access. The dose chosen was 0.5 mg/kg; one that has been used successfully for procedural sedation with no respiratory compromise.

CASE 1
A 15 month old male epileptic had been fitting for two hours before admission despite administration of rectal diazepam (2 × 5 mg). He was given 0.5 mg/kg intranasal midazolam. Fitting stopped within five minutes of treatment.

CASE 2
A 3 year boy had been fitting for 15 minutes. Fitting was seen to stop within 2.5 minutes of administration of 0.5 mg/kg of intranasal midazolam. No patient suffered any respiratory depression, or any other adverse effects.

We feel that the intranasal administration of midazolam warrants further evaluation as a treatment of the fitting child.

RAY McGLONE
M SMITH

Accident and Emergency Department, Royal Lancaster Infirmary, Ashton Road, Lancaster LA1 4RJ UK

Correspondence to: Dr McGlone (ray@mcglone.bbbfree.co.uk)


Communication skills training for emergency department doctors

EDITOR.—It is good to read the two papers in the journal concerning communication training for emergency department doctors. A trained general practitioner I feel that this is a subject that could be given more importance in the training of emergency doctors who spend a large part of their working day consulting with patients. I agree with the authors stating its importance due to; the number of communication based complaints and the stress/anxiety that dysfunctional consultations can cause the doctor. However, difficult consultations in the emergency department have the potential to be a source of huge job satisfaction. The key is in preventing it turning dysfunctional and ensuring that all communications are handled with care and understanding.

However, I wonder how much improvement in consultation skills can be gained at very junior doctor level before the necessary acquisition of hard medical facts and experience has occurred. General practice registrars spend their practice trainee year dedicating a lot of time to learning about and improving their consultation skills—but only after a minimum of two years spent in hospital medicine. Also as the authors mention; consultation deficiencies are not confined to junior doctors. A secondment to general practice would be the ideal environment for emergency doctors to improve these skills assisted by the teaching of general practitioner trainers who are by far the most experienced in this area. Time could be spent in studying various consultation models as described by many authors over the years (Balint M 1957/Byrne and Long 1976/Smith 1984). A number of other published studies have demonstrated an association between PTV and skull vault fractures.

Authoritative guidelines, soon to be published, will suggest that the PTV is included as an indication for skull radiography after head injury in adults, and possibly also in children (personal communication, Mr Ian Swann). Vomiting may be regarded as a fairly sensitive, though not very specific, indicator of fracture risk in alert children after head injury. To ignore this symptom is to risk overlooking a fracture of the skull vault, which substantially increases the risk of intracranial complications.

PATRICK A NEE

Accident and Emergency Department, Whiston Hospital, Prescot, Merseyside L35 5DR, UK
