Poter in their surgery. The National Health Strategy as those who could be on public holidays. In Australia primary care because general practices are usually closed primary care patients on weekdays that were emergency departments. It might be expected that emergency departments would see more primary care patients on weekdays that were public holidays than weekdays that were not, because general practices are usually closed on public holidays. In Australia primary care patients seen by general practitioner services on defined by the National Health Strategy as those who could be managed by a well equipped general practitioner in their surgery. The National Health Strategy opined this as patients in triage categories 4 and 5, the less acute categories. This approach has been used in this study.

To test this hypothesis logistic regression analyses were used to compare the number of patients seen on weekdays that were public holidays with those seen on weekdays that were not public holidays, controlling for the triage category of the patient, the day of the week, the month of the year and the year and clustering on the hospital from which the data were obtained. Data from patients in triage categories 4 and 5 were analysed separately from those in triage categories 1 and 2 because it might be argued that any differences detected arose from changes in patient behaviour because of the public holiday rather than differences in the availability of general practice services. It would not be expected that the availability of general practice services would make any difference to the number of patients seen in triage categories 1 and 2 because these patients have major illnesses that need urgent treatment such as severe immediate serious sequelae and consequently are unlikely to seek care from a general practitioner.

Data were available from over 1.8 million encounters on ordinary weekdays and 93 397 encounters on public holiday weekdays with patients in triage categories 4 and 5 and 158 335 encounters on ordinary weekdays and 6357 encounters on public holiday weekdays with patients in triage categories 1 and 2. No difference was detected between the number of patients in triage categories 1 and 2 seen on public holidays to those seen on working days (p=0.709, OR=0.998, 95% CI 0.986, 1.010), however there was a small but significant increase in the number of patients seen in triage categories 4 and 5 (p<0.0005, OR=1.0199, 95% CI 1.013, 1.027). The sample size used to look for a difference in the number of patients in triage categories 1 and 2 had 99.99% power to detect a difference of the size detected for patients in triage categories 4 and 5.

Findings in Australia suggest that either patients do not perceive emergency department and GPs to be close substitutes and/or that general practice patients are able to defer their requirements for primary care services until they can receive these from a GP. Is this a common experience in other countries?

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The assistance of the NSW Department of Health in providing these data is gratefully acknowledged.

2 National Health Strategy. The immediate impact of the availability of general practitioner services on emergency department presentations and GPs to be close substitutes and/or that general practice patients are able to defer their requirements for primary care services until they can receive these from a GP. Is this a common experience in other countries?

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in innovative and effective treatment strategies. That said, the specific solutions may well be (appropriately) different in different environments reflecting different staff mix or work practices.

Copies of the protocol are available on request from the correspondence address given in the paper.

ANNE-MAREE KELLY
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Open chest cardiac compression

EDITOR—I really wonder about the value of Dr Calinas-Correia’s article on thoracotomy and internal cardiac massage for non-shockable arrested patients. It seems to me that the study only proved the futility of attempting resuscitation this way on these patients. Thoracotomy and internal cardiac massage have a place in the moribund patient with a tamponade and/or penetrating heart wound but this is gung-ho in asystole. The ALS algorithm of early BLS and early ALS must remain the mainstay of attempts to salvage these patients with their universally poor prognosis.

JULIAN KENNEDY
Department of Accident and Emergency Medicine, Royal Bournemouth Hospital, Castle Lane, Bournemouth BH7 7DU UK


Authors’ reply

EDITOR—Dr Kennedy seems satisfied with the work as an upbeat approach as the "universally poor prognosis" of patients in non-shockable cardiac arrest, and clearly defends the unques-
tioned maintenance of the management that achieves that same outlook. The rationale for investigating open chest cardiac massage has been presented within the paper. The indications Dr Kennedy recognises are just some of those accepted by those investigating cardio-
pulmonary resuscitation. Our study presents seven patients, and to take it as proof of efficacy or futility is obviously inappropriate. However, the presentation of data collected under a realistic scenario of cardiol-
upulmonary resuscitation is important to allow the discussion regarding the feasibility and usefulness of further research. What remains of foremost importance is that no study showed worse outcomes with thoracotomy than with closed chest compressions in this group of patients, in fact the results have been slightly better with open chest cardiac massage, even if the significance is far from established. Therefore, the use of thoracotomy remains a matter for further investigation, and a priori dismissive verdict seems more of an aesthetic nature than evidence based. The very short times from thoracotomy to ROSC in three of seven patients that we present should encourage further research, as they corroborate the experimental data on the better coronary per-
fusion obtained with this technique.

J CALINAS-CORREIA I PHAIR

Correspondence to: Dr Calinas-Correia, 16 Roskear, Camborne, Cornwall TR14 8DN, UK
(J.calinas@yahoo.co.uk)

11. Altmoff JK, Safar P, Bircher NG. Opening the chest to keep the brain alive in prolonged cardiopulmonary resuscitation. Pre-Hosp Disas
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tation 1997;34:281–93.

BOOK REVIEWS

Textbook of adult emergency medicine.


This is a major new textbook of emergency medicine first published in 2000.

The contributors read like a “Who’s who” of emergency medicine in Australasia—with a few contributions from North America and UK.

The book is primarily aimed at the emergency medicine trainee—although the wide authorship has allowed the text to become a "snap shot" of current Australasian emergency medicine practice.

The editorial board has adopted a consen-
sus style and approach to the material published. Accordingly extreme views and minority opinion have been excluded. Obvi-
ously in order to keep the book to a manageable size certain topics have been kept brief on the premise that these areas are already covered in established texts. The man-
agement of trauma is the area most noticeably thin and this is acknowledged by the editors in the preface. The result is a comprehensive textbook covering most areas of current emergency medicine practice with recent refer-
ences for further reading.

The text is easy to follow as each subject is set out following a template of Essentials, Introduction, Clinical features, Differential diagnosis, Investigations, Management, Prog-
osis, Disposition, Controversies and Conclu-
sion. This means that for trainees reading the book as part of their medicine study each chapter follows a prescriptive style and the multiple authorship provides credibil-
ity rather than confusion. In my view the three column page layout allows for easy scanning of the material without the feeling of “information overload”.

The contents are listed in a sensible order dealing with Resuscitation and Trauma first—
followed by Cardiovascular, Respiratory, Di-
gestive systems, and so on. There are full chapters on Eye, Dental ENT, Obstetrics and Gy-
naecology and Psychiatric Emergencies as well as Crisis intervention. Ultrasound in emergency medicine is given a chapter of its own in keeping with the interest in emergency ultrasound in Australasia. Various legal and administra-
 tive issues are dealt with providing information on an area often neglected in emergency medicine training. Environmental hazards are covered from heat related illness to altitude illness. The final chapter deals comprehensively with the management of a wide range of toxins and drugs in overdose.

The result is a pleasingly thick book full of up to date information that will be as useful to the specialist as it is to the trainee.

PETE FREEMAN
Auckland, New Zealand


Neurology is not generally perceived as one of the more glamorous medical specialties. This textbook has an upbeat approach to the pref-
ace, the author borrows the now ubiquitous “golden hour” concept for acute neurology.

The text is said to be “brief to facilitate reading” and “is intended to reflect the trainee’s thought and action in the emergency department”. Compared with the average neurological textbook it may be brief but it would not be recognised as such by most emergency physicians.

The book is divided into two sections. The first covers conditions affecting the neuroaxis and the second, neurological disorders attrib-
utable to specific causes. Detailed descriptions of a number of neurological conditions and their aetiology are provided. The usual neuro-
logical emergencies are included, for example, status epilepticus and aneurysmal subarach-
noid haemorrhage. In addition rather less obvious emergencies such as acute obstructive hydrocephalus and acute white matter disease are also discussed. The chapter on altered arousal and coma contains an exhaustive list of the major causes of coma, some of these conditions are unlikely to present a differential diagnosis formulated in the emer-
gency department. However, the detail con-
tained within the sections on examination of the patient in coma and the assessment of patients with acute unwell masses re-

www.emjonline.com

Letters, Book reviews, Abstract, Notice

Emerg Med J: first published as 10.1136/emj.18.4.321 on 1 July 2001. Downloaded from http://emj.bmj.com/ on October 12, 2023 by guest. Protected by copyright.
minded me of a number of long forgotten clinical signs. In many chapters there is a brief but detailed and informative review of anatomy and pathophysiology.

Many of the investigations, for example, EEG, SPECT suggested in other chapters might be problematic to arrange in the average emergency department. “I want a SPECT stat”

In parts the clinical practice described does not follow current UK practice (or even standard clinical practice of 10 years ago). For example, it is implied that the administration of antibiotics in bacterial meningitis be delayed until CT/MRI and lumbar puncture have been performed.

The book is unlikely to be used “acutely” on a daily or weekly basis. I suspect this book is akin to an interview suit, something to be read on a daily or weekly basis. I suspect this book is of antibiotics in bacterial meningitis be delayed until CT/MRI and lumbar puncture have been performed.

In this second edition David Currie, a Scottish neurosurgeon, has been joined by two anaesthetists to provide a handy guide for the management of patients with head injuries aimed instead of immediately working in the emergency room andward setting. A welcome addition is the excellent chapter on the disturbed patient, which will be appreciated by nurses on wards that are often under staffed. Advice with which most A&E specialists would agree includes “observation should ideally be undertaken on a neurosurgical ward”.

There could be more detail on the practical issues of how the “frontline” staff can safely and efficiently sort out difficult patients with complex problems. When they arrive in A&E, patients rarely have “isolated head injury” stamped on their foreheads yet I believe this is the way neurosurgeons would like to receive them. The management of potential alcohol withdrawal deserves more than a mention. I am concerned about the use of a contraction of the 15 point GCS score to a total of 14—this could create confusion in clinical discussions if the score is used without clarifying the denominator, for example, GCS > 8 instead of < 9 is given in the section for intubation and ventilation. The importance of describing the levels of the three responses and avoiding numbers should be emphasised.

It is good that ATLS principles are espoused and there is an expanded chapter on cervical spine injuries but the inappropriate term “traction” is still used rather than “in line immobilisation”. Scalp “lacerations” should be differentiated from “incised wounds”—an important clue to the likely mechanism. Some typographical errors and mislabelling are retained and, in my copy, the clarity of some photographs has deteriorated compared with first edition.

Possibly because of the timing of this edition, it excludes the guidelines for the initial management of head injuries by the Society of British Neurological Surgeons (1998), which, for example, recommend computed tomography within four hours for GCS 15 patients with skull fracture.

This book about a common A&E presentation is written mainly for A&E staff by non-A&E specialists. To justify its title there needs to be a greater focus on what really happens in the emergency room everyday and an up to date view of what we should be doing in the future.

JOHN HEYWORTH
Consultant, Accident and Emergency Medicine,
Southampton General Hospital


The late great Ernie Wise was the perfect example of an author so dizzled by the brilliance of the plays what he wrote that he was blind to the inherent flaws. Unfortunately, such delusions of literary grandeur are not unique and some authors seem to have difficulty in accepting that we are not all imbued with natural skills in the art of writing. Indeed, Richard Asher, regarded by many as the doyen of medical writing, prepared draft after draft of his articles before allowing them to proceed.

In this superb book by Tim Albert, there are fascinating and invaluable insights into the creative process. The style is hugely accessible and entertaining. One of the major highlights is official permission at last to boldly split infinitives!

The author writes with over 10 years experience of working with doctors to sort out a wide range of writing problems, noting that doctors have usually had no formal training in writing since they were 16, and are expected to publish in high status journals if they are to advance in their careers.

There are a large number of topics arranged alphabetically from abbreviations (for some reason Aardvark is overlooked) to zzzz. The book is intended to be dipped into for morsels as required including top tips on preparing your CV, writing style, scientific papers, references, press releases, posters, newsletters and even obituaries. The previously mysterious world of writing terminology is unveiled with explanations of IMRAD, salami publication, peer review and the impact factor. The sections on how to deal with rejection and editor (dealing successfully with) were particularly useful for this author.

For anyone considering dipping a toe into the literary pool or those who are already out of their depth, this book is an absolutely invaluable aid.

JOHN HEYWORTH
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In this second edition David Currie, a Scottish neurosurgeon, has been joined by two anaesthetists to provide a handy guide for the management of patients with head injuries aimed instead of immediately working in the emergency room andward setting. A welcome addition is the excellent chapter on the disturbed patient, which will be appreciated by nurses on wards that are often under staffed. Advice with which most A&E specialists would agree includes “observation should ideally be undertaken on a neurosurgical ward”.

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IAN SWANN
Consultant in Accident and Emergency Medicine,
Glasgow Royal Infirmary

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.

Minor injury services—the present state
M W COOKE, J HIGGINS, P BRIDGE
Emergency Medicine Research Group, Centre for Primary Health Studies, University of Warwick, Coventry

Introduction—There are no studies describing the present systems of care in minor injury units. BAEM has recently issued a position statement but it is not known how many units adhere to this.

Methods—Postal questionnaire to all minor injury services in the UK.

Results—There was a 65% response rate. Units described themselves as minor injury services (32%), injury and illness services (24%). Eight per cent receive all local 999 ambulances but 24% receive none. The distance from the A&E department was under 10 miles for 9% of units. Only half are open 24 hours per day although most are open seven days a week. GPs are the main provider (49%); with ENP the main provider in 27%. Only 15% had doctors permanently based in the unit and 50% had nurses permanently based in the department. Only 4% of nurses rotated with A&E. Over half did not have staff with ALS on duty at all times. They had high review rates.

Conclusions—Structure and staffing are highly variable. Most do not conform to BAEM guidelines. Optimal configuration is not known. More A&E input may be beneficial. Full report available at www.emerg-uk.com on reports page.

Funding—Department of Health A&E Modernisation Programme.

NOTICE

1st Kuopio Conference.
“E-Health”—The use of information technology and telematics in emergency management and education

23–25 August 2001, Kuopio, Finland

Further details: Conference Secretariat, University of Kuopio, Department of Health Policy and Management, PO Box 1627 FIN-70211 Kuopio, Finland (tel: + 358 17 163 631, fax: + 358 17 162 999, e-mail: aapo.immonen@uku.fi).