LETTERS TO THE EDITOR

Physostigmine as treatment for severe CNS anticholinergic toxicity

EDITOR,—We report the successful use of physostigmine to treat central anticholinergic toxicity: a use described before but rarely seen.1 We treated a patient admitted after an overdose of amisulpride and procyclidine (not his own medication). He became extremely agitated and was treated with intravenous benzodiazepines (total quantity in 26 hours equivalent to 125 mg diazepam) but remained agitated. Because of the risks of serious injury if his agitation was untreated and of further benzodiazepine use outside a critical care area (the ward to which he was admitted has a patient:nurse ratio of 8:1), he was treated with 1 mg of physostigmine. This was immediately and dramatically followed by a period of complete lucidity lasting 90 minutes. He did not become agitated again and his confusion resolved fully after a further 16 hours. Referral to an ICU was considered but it was felt that the risks of paralysis, intubation and ventilation (and the possible need for interhospital transfer) outweighed those associated with physostigmine treatment. This latter option had the advantage of therapeutic and diagnostic potential.

Procyclidine is an antimuscarinic drug with a half life of 8 to 16 hours. When taken in overdose the features of anticholinergic toxicity may be delayed.2 His agitation was unlikely to be attributable to amisulpride as this is a D2/D3 receptor antagonist but the patient had no signs of extrapyramidal side effects.3 Physostigmine is a tertiary ammonium compound that reverses anticholinergic effects via acetylcholinesterase inhibition. Uniquely, for this class, it crosses the blood-brain barrier. It has a rapid onset of effect and duration of action of one to two hours.1

We do not propose that physostigmine be routinely used to treat changed mental status after poisoning. We do, believe, however, that it has a very specific role in the treatment of poisoning with persisting central anticholinergic toxicity despite sedation with benzodiazepines.

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Emergency medicine or accident and emergency?

EDITOR,—What is emergency medicine? Is it the specialty that provides “The care of emergency patients . . . by specially trained doctors who deliver a wide range of services for all patients presenting to a separate emergency department” including “The initial assessment and early treatment in resuscitation, trauma, medical and paediatric emergency” and “acute care of patients” in its widest context including medicine, surgery, anaesthe sia, paediatrics (and) psychiatry”? Or is it a subspeciality of general medicine responsible for the assessment and admission of acute adult medical conditions?

The Royal College of Physicians has named the latter “acute medicine”, yet confusion about the distinction remains.

We have reviewed 10 successive editions of BMJ Classified (14 October 2000 to 16 December 2000) in order to identify all job advertisements for “emergency physicians” or doctors to work in “emergency medicine”.

Further study of the advertisements allowed me to establish which of these posts were to work in (accident and) emergency departments and which to work in medical assessment/admission units and/or general medicine (table 1).

Table 1 Number of advertisements for “emergency physician” or “emergency medicine” by grade and specialty

<table>
<thead>
<tr>
<th>Grade</th>
<th>Non-emergency or emergency medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>2</td>
</tr>
<tr>
<td>Non-consultant career grade</td>
<td>1</td>
</tr>
<tr>
<td>Training grade</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
</tr>
</tbody>
</table>

The results of this study show that the majority of positions in “emergency medicine” (11 versus 6) are in fact to work in acute general medicine.

I believe that it is now time for our specialty to adopt the name emergency medicine, to bring us in line with our colleagues in the USA, Canada, Australia, New Zealand and the Far East. If we do not, we are in danger of losing the title altogether to a subspeciality of general medicine. If this were to happen, we would be stuck with “AcE” which, along with its predecessor “casuistry”, belong firmly in the last millennium.

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1Saile M, Wardrope J. Casualty, accident and emergency medicine, the evolution of “casualty”, including “emergency medicine”. In: Fields HL, Dubner R, Cervero F, eds. Advances in pain research and therapy. New York: Raven Press, 1985:395-402.

Pain in young children attending the accident and emergency department

EDITOR,—We read with interest the article by Macarthy et al.1 We too have experienced difficulities assessing and scoring children’s pain in the accident and emergency (A&E) setting. We feel that while subjective assessment has been shown to be the gold standard of pain assessment in some settings, for example, postoperative pain, the unexpected nature and anxiety associated with attendance at the A&E department makes this type of scoring invalid.

We have been working on developing an observational one for the assessment of pain in children presenting to the A&E department. We know from experience of auditing analgesic use in A&E that children who have a pain score allocated receive more analgesia in a more timely fashion than those who do not.

Our pain score is loosely based on both the TPS’ and CHEOPS’ score and relies on observations of various parameters in five categories (1) cry/vocal expression, (2) colour, (3) facial expression, (4) posture, (5) movement. Each score receives a value of 0, 1 or 2 to give a maximum total of 10 (similar to the mechanism of a Paagor score).

This score has been validated by medical students (Davis and Rostron 3) in the department and has shown to have good inter-rater reliability (Spearman’s rank correlation 0.82) and to have also significant construct validity when compared with patients who presented with similar conditions. We feel that this score can be extended from the age of one year right through the paediatric population and not be just restricted to under fives, as we have experienced problems with subjective pain scoring in all age groups presenting to the department.

We endorse the suggestion that exploration of such pain scores in the A&E department should be actively pursued and intend to further validate our Alder Hey score against the modified TPS score as the author suggests.

EMERGENCY MEDICINE OR ACCIDENT AND EMERGENCY?

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Intranasal diamorphine in adults

EDITOR,—We would like to describe a patient who benefited from intranasal diamorphine administration. This route has become an acceptable and potentially important route for administration of pain relief in a 57 year old woman. We believe it is also an acceptable and potentially important route for adults. It is rapidly absorbed from the venous plexi of the nasal mucosa and provides less variable pain relief than rectal or oral routes. Its aqueous solubility allows the use of small volumes.1

We recently used intranasal diamorphine as pain relief in a 57 year old woman. This woman suffered with chronic renal failure, and underwent frequent haemodialysis. She had fallen onto her right hand. Her right forearm. This combined with an arterio-venous shunt in the left arm made venous access difficult. She was crying out in pain and severely distressed. To allow immobilisation she was given intranasal diamorphine.

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revealed a displaced four part supracondylar fracture of the right humerus with an intra-articular component.

Although the oral or intravenous routes remain the most favoured for analgesia, it is our experience that they are not always available. The oral route may be inaccessible, for example, in a hard collar or may take longer to work because of delayed gastric emptying. Intravenous and intramuscular routes are alternatives but a patient may refuse such analgesia because of a dislike of injections. The intramuscular route also has delayed action. The rectal route can be embarrassing and uncomfortable. Rapid analgesia may be necessary and the intranasal route provides this when intravenous access cannot be secured or is not strictly necessary. We have used intranasal diamorphine on several occasions. During its use we monitor vital signs. Pain scores or direct questioning measures its efficacy.1 We believe that a prospective study of its use would permit identification of potential side effects or complications. It is our experience that these do not occur. Our experience is insufficient to identify nausea and vomitting which would be a significant problem.

We feel it is an important adjunct in certain clinical situations and a valuable addition to pain management.

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The role of non-invasive ventilation in the emergency department

EDITOR,—Anthony Cross highlighted the effectiveness of non-invasive ventilation (NIV) in the emergency department in his review. As he concluded, studies certainly indicate that this treatment is beneficial in the treatment of acute exacerbation of chronic obstructive airways disease—with regard to the need for intubation, length of hospital stay and mortality.

The evidence for the use of NIV in the treatment of acute pulmonary oedema also exists, and is stronger than Dr Cross indicated. In addition to the three randomised controlled trials comparing chronic positive airway pressure (CPAP) with standard treatment of acute pulmonary oedema published in the review, there are also an article by Takeda et al from Tokyo.8 If the results of this study are pooled with the three reviewed by Cross, the overall risk reduction for mortality becomes 13.8% (95% CI 24.2 to 3.4%). The interesting thing about this finding is that the confidence interval does not cross zero. This is the first time that pooled results have shown that CPAP treatment for heart failure, in increasing intrathoracic hydration, also decreases mortality—at least in the short-term (only two of the studies included long term follow up). There is also evidence that CPAP treatment benefits are greater in those with increasing severity of pulmonary oedema.

There remains a need for a large prospective randomised controlled trial into the effectiveness of NIV compared with standard treatment of acute pulmonary oedema. If the results confirm the trends suggested in the available smaller studies, it should be sufficient to change our current treatment practice in UK emergency departments regarding acute pulmonary oedema. Admissions and death attributable to heart failure, unlike those attributable to other chronic diseases, are predicted to increase. CPAP has been shown to be effective in reducing the number of these patients intubated, admitted to intensive care units or dying. Personally, I believe that there already exists evidence for the necessity for the acquisition and use of CPAP/BiPAP machines to treat acute pulmonary oedema in all emergency departments in the UK.

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You can’t anaesthetise patients—you are not employed as an anaesthetist

Editor,—I would like to highlight an example of “speciality in training problem” and how the problem may be tackled. Although I was an anaesthetist for over three years and possess the anaesthetical fellowship, I have come into criticism from anaesthetists for intubating patients using anaesthetic drugs in my role as Specialist Registrar in Emergency Medicine (year 5). The first time it happened I ignored the criticism, but it has occurred since in different English hospitals. There are several issues arising out of this.

(1) There is a need to inform anaesthetic colleagues that not only is anaesthesia a core secondment but specialist registrars are keen to put the skills into practice.

(2) There is a need for individual clinicians to audit their practice of intubating patients in the emergency department. My personal logbook (kept on Microsoft Access) covers patient name, date, indication for intubation, drugs and anaesthetics used, morbidity and mortality. It thus covers not only the “flat or oesophageal” or “coma ?subarachnoid” but also patients who arrive in cardiac arrest unintubated.

(3) There is a risk management need, as a specialty, to nationally audit morbidity and mortality in relation to patients being intubated by emergency department staff. In addition to the criteria above, timeliness and appropriateness of intubation should be considered.

So what if we do not audit this particular area of activity? When the inevitable disaster happens the clinical governance committee of the hospital may judge rapid sequence induction and intubation to be a procedure for the elite few doctors who satisfy the following criteria: confident, competent, qualified and employed as anaesthetists.

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BOOK REVIEWS


Seventy five years ago an American advertising executive wrote that "one picture is worth ten thousand words". The aphorism holds particularly true for busy junior doctors preparing for examinations. This little book offers 150 pictures; clinical images, radiographs, tables of monitored data and diagrams to explain basic principles. The book is aimed at medical students, critical care trainees and surgeons in training. However, the topics covered are not exclusive to intensive care medicine and many conditions relevant to the emergency physician are included. Trauma, toxicology and resuscitation topics are among the 272 cases contributed by an international group of 30 intensivists.

The authors set out to assist the reader in understanding what they call “the science and Gestalt of critical care medicine”. I take this to mean that the clinical formulation should be determined by interpretation of the clinical scenario in the appropriate context, taking account of any technical and other confounding variables. These aims are equally appropriate to emergency medicine but I’m not sure that they are achievable in a book of this size and type.

The format is a familiar one; questions are posed on one side of the page with answers and explanations overhead. The quality of the images is above average and the subject matter is not overly esoteric. Answers are commendably brief and informative, allowing a wide range of material to be covered fairly quickly, though not in great depth.

Accessible is the best way to describe this book, light reading in quiet moments before postgraduate examinations in critical care, anaesthesia or accident and emergency medicine. When junior doctors wore white coats it would have been crammed into a big brown folder. Nowadays it will reside instead in numerous clinical areas or languish on a bed-side table in the on call room. I recommend that if you come across it you should pick it up and have a read.

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When I picked up Trauma care I was expecting another run of the mill text on “how to resuscitate the multiply injured”. This expectation was shaken when the book fell open on the chapter “nutrition”. Now I know waiting times in A&E are long but surely no one was advocating taking the breakfast trolley into “resus”? All was revealed however as I read on. The book takes a much wider view of trauma care than is normally experienced by those of us who work in A&E. It is not destined for the nurse wanting to know how to resuscitate the multiply injured, but instead is a text outlining the delivery of optimum trauma care from the moment of initial contact to the re-integration of the patient into the community. The approach is fresh and is enhanced by the use of case studies to illustrate the points being made. The most compelling thing is that a large amount of the book seems to be written from the perspective of the patient—the patient’s experience, the patient’s needs. The chapters that focus on the psychological effects of trauma are perhaps the most sobering, but other elements of care that are important to the patient are also covered—elimination, tissue viability, hygiene and mouth care to name but a few. But don’t be fooled into thinking that this is purely a nursing textbook—the contributors come from all disciplines involved in the care and rehabilitation of the trauma patient, with many team members writing their own chapters in the book. The book is made complete with considerations in the final section of the actual service delivery and the staff that work within the service.

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This book has succeeded in making me rethink my often narrow approach to trauma care, and I have set myself the task of recommending it to all the areas within the hospital that have contact with “trauma patients”. I hope that if I ever have the misfortune to be seriously injured I am looked after by people who have a similar patient orientated approach.

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CORRECTION

Mr R A Simpson should have been acknowledged as a scan coordinator for the Journal scan that appeared in the January 2001 issue of the journal (2001;18:71–3).

NOTICES

15th Annual Trauma Anesthesia and Critical Care Symposium
23–25 May 2002, Stavanger, Norway
Further details: e-mail: congress-secretary@traumacare2002.com, web site: www.traumacare2002.com, tel: +47 51 74 91 02, fax: +47 51 74 70 02.

18th Annual Scientific Meeting of the Australasian College for Emergency Medicine, incorporating the 22nd Annual Scientific Meeting of the Australasian Society for Emergency Medicine
30 September to 4 October 2001, Hobart, Tasmania
Further details: the programme of the meeting and details of how to register are at the web site www.cdesign.com.au/acem2001

World Congress on Drowning
26–28 June 2002, Amsterdam, the Netherlands
Further details: Congress Secretariat World Congress on Drowning 2002, Consumer Safety Institute, PO Box 75 169, 1070 Amsterdam, the Netherlands (tel: +31 20 511 45 14, fax: +31 20 511 45 10, e-mail: Secretariat@drowning.nl, web site: www.drowning.nl).

Books received