Hand injuries in young children from contact with vacuum cleaners

D Macgregor

Objectives: To assess the incidence of injuries to young children sustained by contact with a domestic vacuum cleaner and to highlight the potential for significant injury. An increase in public awareness of these risks might result in a reduction in morbidity.

Methods: Over a period of one year, all children attending with an injury sustained because of contact with a domestic vacuum cleaner had review of their case notes by the author.

Results: Four children were identified as having sustained friction burns to a hand after contact with a vacuum cleaner. All required treatment and several review appointments before satisfactory resolution was achieved.

Conclusions: Although the number of cases seen was small, the potential for significant injury must be emphasised and public awareness increased in an attempt to reduce morbidity.

RESULTS

During the year of the audit four children (two boys and two girls) presented with a hand injury sustained by a contact with a domestic vacuum cleaner. The children were all under the age of 2 years (10 months to 23 months). The injuries were all sustained by putting a hand under a domestic vacuum cleaner that was either running or immediately after switching off of the machine when the rotors were still turning. The injuries were caused by the rapid rotation of the stiff nylon bristles on the vacuum cleaner's brush cylinder, resulting in friction burns with superficial skin loss in all four cases. All the injuries were sustained on the palmar aspect of the hand. All four injuries were superficial with no tendon, nerve or vessel damage. After cleaning, the areas of skin loss were treated according to the departmental burns policy with mupirocin 2% cream, a mepitel dressing and protective bandaging of the hand. Each case was subsequently reviewed at the A&E dressing clinics—several appointments were required for each patient until there was satisfactory resolution of the injury. None of the friction burns became infected and all healed well with this regimen. There was no long term disability in any of the four cases. Another recent case was recalled by staff when a small child had presented having sustained a superficial friction burn to the dorsum of the foot after the foot had become trapped under a domestic vacuum cleaner. Unfortunately we were unable to trace this child's clinical records.

DISCUSSION

A literature search was done (Medline and Embase from 1966) but only one paper was found reporting an injury to a child sustained by a vacuum cleaner.1 In this case there was a full thickness burn to the hand of a young child. The only other related report was an 1984 paper on electric burns to the mouth from defective Bakelite plugs on vacuum cleaners. There were however, several reports of injuries to adults from vacuum cleaners, most because of the use of vacuum cleaner attachments being used by adult men for self gratification!

The stiff nylon bristles of vacuum cleaner brushes and the high speed of revolution of the cylinders have the potential for serious injury. Tendon, nerve and vessel damage are all possible. There may be a higher risk of injury in the more modern cleaners, which have greater “suction power” because of the increased speed of revolution of the cylinders. All hand injuries must be taken seriously and the potential for long term disability must not be underestimated.

Virtually all households own a domestic vacuum cleaner and these are often used daily—particularly when there are young children in the family. Young children crawling or playing on the floor may be in close proximity to these appliances and parents and carers may not be aware of the potential for serious injury from such a common household appliance. We recommend that the risks of injury from domestic vacuum cleaners should be highlighted and that advice to keep children away from these appliances should be included in all injury prevention material in an effort to increase public awareness of the potential for significant injury.
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PAEDIATRIC RADIOLOGY

Buzz Lightyear

The radiograph of Buzz Lightyear has been used as a tool to explain to children the need for
a radiograph. We often refer to Buzz Lightyear’s catch phrase “To infinity and beyond” as he
jumped and then fell injuring a limb. Most children are able to relate to this and it allays
some of their fears regarding radiographs.

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Calcium for hyperkalaemia in digoxin toxicity

In their article on the management of hyperkalaemia, Dr Aheic and Dr Crowe recommend, “hyperkalaemic patients taking digoxin should be given calcium as a slow infusion over 20 to 30 minutes.” I would caution against this advice.

Hyperkalaemia is usual in acute digoxin toxicity, and not uncommon in chronic digoxin poisoning. Additionally, because it undergoes significant renal clearance, digoxin toxicity is probable in a patient with acute renal failure. Therefore, patients taking digoxin who present with ECG changes and hyperkalaemia should be considered digitoxic.

It is widely held (though at times hotly debated) that calcium administered in the setting of digoxin toxicity will probably induce arrhythmia or cardiac arrest. Immediate reversal of digoxin toxicity with digoxin antibody (Fab) fragments will rapidly reduce toxicity reversal of digoxin toxicity with digoxin antibody (Fab) fragments will rapidly reduce serum potassium and is the treatment of choice. In the absence of Fab fragments, treatment with magnesium sulphate rather than calcium should be considered. Magnesium sulphate has been shown to be effective for digoxin induced arrhythmias and there is latent and some clinical evidence to suggest that magnesium exerts similar effects to that of calcium on the trans-membrane potential in the setting of hyperkalaemia.

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References

What about patient satisfaction following acute ankle sprains?

Investigation of the effectiveness of double Tubigrip for acute grade 1 and 2 ankle sprains through a randomised controlled trial [is commendable]. However, I feel compelled to comment on aspects of this study. It is interesting that 85 (17.5%) of the 485 patients approached to take part in this study expressed a treatment preference and therefore were not randomised. Given that only 197 patients completed the study, the 85 expressing a treatment preference is equivalent to a third arm of the study. The implication of their reluctance is that patients attending the accident and emergency (A&E) department after ankle injuries expect and want treatment. This confirms what is a commonly held belief in the A&E department—that a double Tubigrip, or any other treatment option is supportive to the patient. While this support may not be of a physical nature, it probably leads to improved patient satisfaction. To that end, I would suggest that the addition of a “patient preference” limb to the study would be as important as the existing two limbs.

It is equally interesting that the authors did not measure patient satisfaction as an outcome in this study. One important facet of any clinical trial is that it is acceptable to patients—and the application or not of a double Tubigrip after ankle sprain is no exception. Although the authors found the application of a double Tubigrip did not shorten recovery time or number of days off work, it would be helpful to identify whether patient preference and satisfaction would have affected outcome, both in terms of actual recovery time, but also during the recovery period itself.

While in agreement that patient education might reduce reliance on this type of treatment, in the context of a busy A&E department, this may not be practical, and the current approach probably provides efficient patient satisfaction.

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References

Table 1

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<thead>
<tr>
<th></th>
<th>DTG group</th>
<th>No DTG group</th>
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<tr>
<td>Preference for DTG (%)</td>
<td>73 (76.8)</td>
<td>77 (77.8)</td>
</tr>
<tr>
<td>Preference for No DTG (%)</td>
<td>22 (23.2)</td>
<td>22 (22.2)</td>
</tr>
<tr>
<td>Satisfaction score (average)</td>
<td>8.2</td>
<td>8.2</td>
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</table>

Author’s reply

We thank Miss Mason for her comments on our paper. Firstly, we certainly agree that the investigation of patient preference for a treatment is an important and interesting factor in a study such as ours and indeed we set out to include this group in our research. Patients who expressed a treatment preference and agreed to the follow up telephone questionnaire were enrolled and were given the treatment of their choice. The aim was to compare their outcomes and satisfaction scores (see below) with those who were randomised to treatment. However, because of a communication error at one of the study sites, a large number of the preference group were not followed up, making comparison with the randomised group impossible.

Secondly, we did attempt to measure patient satisfaction as an outcome measure in our study. Patients were asked how strong their preference for treatment with or without a double Tubigrip bandage was on enrolment, using a 0 (no preference) to 10 (very strong preference) scale. When telephoned a week after entry, patients were asked to rate their overall satisfaction with the treatment they had received from 1 (very dissatisfied) to 10 (very satisfied). However, when we came to analyse the data we found that both these questions were poorly answered and we therefore did not include this information in our final paper. The raw results are shown in table 1.

It would seem from these raw data that of those patients who expressed a treatment preference (while agreeing to randomisation), the majority would have preferred to be treated with a double Tubigrip bandage, as expected by most clinicians. However, when asked to rate their overall satisfaction with treatment, there is no difference between the groups.

We feel that provided patients are given comprehensive information about their injury and what they should do to hasten recovery, satisfaction can be maintained without the reflex application of a bandage that adds nothing to recovery and may increase the need for analgesia.
Two cases of near asphyxiation in children, using non-releasing plastic garden ties

We read with interest the emergency casebook featuring two cases of near asphyxiation. It is our practice to admit all cases of near strangulation who present early with signs of symptoms in keeping with the history for a period of observation. We adopt this policy on the basis that it is possible to miss occult, significant upper airway pathology in victims of near strangulation and airway obstruction can present as late as 36 hours after such an event. In addition it is possible to overlook visual impairment in such patients as subtle changes in visual acuity may not initially be apparent. Cases of near asphyxiation in children are not widely reported in the literature and therefore it is difficult to have an evidence based admission/discharge policy. Are we being over cautious?

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References

Author’s reply
We agree entirely, the experience with asphyxiation in children is limited and therefore there is no evidence base as to what is the most appropriate admission/discharge policy. At the Birmingham Children’s Hospital we are fortunate in being able to observe less sick children in an accident and emergency based observation bay, in case they get delayed respiratory symptoms, and therefore do not need to admit many children to the paediatric wards.

We were interested to note the reference to subtle changes in visual acuity by Baldwin et al. This suggests it would be wise to consider visual acuity testing a few weeks after such an incident and we would certainly look towards providing diagnostic confirmation and estimation of drug sensitivity. However, in many instances, the diagnosis of tuberculosis is difficult to verify. For instance, acid fast bacilli may not be identified on biopsy or may be non-tuberculous in origin. Additionally, subsequent culture confirmation can take several weeks or may fail completely, because of the fastidious nature of TB.

Although the reliance on clinical suspicion is the basis for the diagnosis of many cases of TB, definitive confirmation is desirable in view of the long term nature of treatment. It is also important to ensure that the organism is not resistant to the chemotherapeutic regimen being used, particularly with the increasing incidence of multidrug resistant TB strains. A number of molecular techniques have been developed to facilitate this. The use of the polymerase chain reaction to amplify specific TB DNA sequences permits a rapid confirmation of the diagnosis and an estimation of drug sensitivity. These techniques have been successfully used on both clinical specimens and culture material. Thus, acid fast bacilli can rapidly be identified as Mycobacterium tuberculosis and an estimation of rifampicin sensitivity can be obtained in a matter of days, free from the constraints of waiting up to several weeks for the standard culture to grow. These techniques should therefore be considered in particular if the clinical findings are subtle or atypical.

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Tuberculous osteomyelitis

Yuen and Tung describe a case of tuberculous osteomyelitis. The potential difficulties in making the diagnosis. The authors were fortunate enough to have typical histological biopsy findings that subsequently cultured Mycobacterium tuberculosis (TB), providing diagnostic confirmation and estimation of sensitivities. However, in many

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M C Yuen, W K Tung

References

Journal clubs in clinical medicine

Journal clubs in clinical medicine have long been recognised as a useful tool for keeping up to date with new developments. More recently they have been used as a tool for the teaching of critical appraisal, which for emergency medicine trainees in the UK is an important part of their final fellowship examination.

Since the inception of our journal club we have noticed a subtle change in both the quality and quantity of papers in the journals that we chose to review. This made it more difficult to combine both the educational value of critical appraisal and keeping up to date with the relevant advances in our specialty so that we can apply to our practice of evidence based medicine.

To address this we undertook to review our choice of journals to try to increase our yield of relevant articles. After finding a complete journal list from Medline a consensus opinion was reached on the basis of relevance to practice, past experience of quality of papers, and personal choice. The number of times per year that the journals, or groups of journals, are reviewed depends on the number of issues per year and the likelihood of finding papers relevant to emergency medicine in them.

The complete list of journals and their review rates is shown in table 1.

We believe that all departments with a journal club should regularly revise their selection of journals in order to increase the value of this important educational process.

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References
1 W F Crawford, B Ali, E Beattie, S Carley, M Davies, A Ghosh, B Martin, H Paul, R Boyd, K Mackway-Jones, R J Morton Department of Emergency Medicine, Royal Infirmary, Oxford Road, Manchester M13 9WL, UK

www.emjonline.com

PostScript
A misdiagnosed fracture of the calcaneum

I am writing in response to the interesting case report of “A misdiagnosed fracture of the calcaneum.” The author, having accepted the original diagnosis of partial Achilles tendon rupture was incorrect, suggested on expanding the criteria for radiological assessment in doubtful clinical cases. It was obvious from the history that the injury was sustained as a result of minimal trauma, in a patient with significant risk factors for osteoporosis. Coupled with an examination finding of a palpable gap in the Achilles tendon/calcaneal complex, the incorrect diagnosis was made solely on a negative Simmonds test. With these clinical findings and the published lateral radiograph of the calcaneum, I do not accept the original opinion of a negative Simmonds test. Simmonds’ or similarly Thompson’s test, has been shown to be a reliable sign for complete Achilles disruption, with a diagnosis of partial rupture being a rare occurrence!

The lesson to be learnt from this case is not how to increase our diagnostic accuracy with the history and performing a sound clinical examination. The last thing we need is to generate protocols and criteria to make up for our shortcomings. Please note the correct spelling for Simmonds!

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References

Table 1  Frequency of journal review

<table>
<thead>
<tr>
<th>Journal</th>
<th>Reviews per year</th>
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<tbody>
<tr>
<td>Academic Emergency Medicine</td>
<td>4</td>
</tr>
<tr>
<td>Annals of Emergency Medicine</td>
<td>4</td>
</tr>
<tr>
<td>British Medical Journal</td>
<td>4</td>
</tr>
<tr>
<td>Lancet</td>
<td>4</td>
</tr>
<tr>
<td>Medical journals (Archives of Internal Medicine, Annals of Internal Medicine, Clinical Medicine, Chest, Cardiology, Circulation, etc)</td>
<td>4</td>
</tr>
<tr>
<td>New England Journal of Medicine</td>
<td>4</td>
</tr>
<tr>
<td>Paediatric Journals (Archives of Disease in Childhood, Pediatric Emergency Care, etc)</td>
<td>4</td>
</tr>
<tr>
<td>American Journal of Emergency Medicine</td>
<td>3</td>
</tr>
<tr>
<td>Emergency Medicine Journal</td>
<td>3</td>
</tr>
<tr>
<td>JAMA</td>
<td>3</td>
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<tr>
<td>Intensive care journals (Anesthesia and Intensive Care, Critical Care Medicine, Intensive Care Medicine, etc)</td>
<td>2</td>
</tr>
<tr>
<td>Journal of Trauma</td>
<td>2</td>
</tr>
<tr>
<td>Reanimation</td>
<td>2</td>
</tr>
<tr>
<td>Anaesthetic journals (Anesthesia, Anaesthesia and Intensive Care, British Journal of Anaesthesia, etc)</td>
<td>1</td>
</tr>
<tr>
<td>Burns</td>
<td>1</td>
</tr>
<tr>
<td>European Journal of Emergency Medicine</td>
<td>1</td>
</tr>
<tr>
<td>Injury</td>
<td>1</td>
</tr>
<tr>
<td>Injury Prevention</td>
<td>1</td>
</tr>
<tr>
<td>Nursing journals (Accident and Emergency Nursing, Emergency Nurse, Journal of Emergency Nursing, etc)</td>
<td>1</td>
</tr>
<tr>
<td>Sports journals (American Journal of Sports Medicine, British Journal of Sports Medicine, etc)</td>
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Screening for alcohol misuse

The Paddington Alcohol Test (PAT) confers considerable advantage over the CAGE as the accident and emergency (A&E) screen for alcohol misuse. Haddad et al’s commendable study identified 28% (out of 413) A&E attendees as having an alcohol related problem. A pilot study using the CAGE, run in our department a decade ago, had a very low pick up rate, which was one of the reasons behind the development of the PAT. Our recent study, using the PAT, had an overall detection rate of 6.4% rising to 9.8% in the third month after intensive audit and feedback. Four features could explain the discrepancy:

1. (in the PAT study only 61.1% of patients had presenting complaints mandating the test. The detection rate for this group (in month 3) was 14.3%.
2. (in this group, 62 patients of 286) were missed—that is, did not have the test applied.
3. The Haddad et al study identified a number of misusers by “staff assessment”. The basis of this assessment is unclear. Two questions are paramount: (a) Was an alcohol history taken?, (b) Did the patient agree with the doctor/nurse’s assessment?
4. (the Haddad et al study effectively had an extra member of staff run the screening protocol—whereas PAT usage simply reflects our own routine practice, with no extra staffing.

Studies suggest the CAGE detects dependent rather than hazardous drinkers, a point rightly discussed by Haddad et al, and emphasised elsewhere. Compared with dependent drinkers, hazardous drinkers (earlier on in their drinking history) are more likely to respond to brief interventions.

The PAT is designed specifically for use by A&E practitioners, to detect hazardous as well as dependent drinkers. Detection is not indiscriminate but guided by “The Top Ten” presenting conditions, whereby screening is targeted and most effective. Furthermore, question 3 of the PAT—“do you feel your current attendance in A&E is related to alcohol?”—helps reinforce the idea that their presenting problem may be alcohol related, even if the patient were to refuse help on this occasion. As the number of A&E departments that work with alcohol health workers increases it is hoped that the worth of the PAT will be further recognised.

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References

Authors’ reply

We thank Huntley and colleagues for their comments on our paper. They make the point that the Paddington Alcohol Test “is a better instrument for screening for alcohol problems in the emergency department than the CAGE.” We would not take issue with this.

The main aim of our study was not to investigate the sensitivity and specificity of
different screening tests, but rather to show the feasibility of screening high proportions of patients as a first step towards intervention. We successfully screened 413 of 429 patients (96%), a much higher proportion than other studies.7 As Huntley et al point out, this may reflect the fact that we effectively had an extra member of staff to run the screening. In addition we chose to recruit a representative flow sample of patients rather than consecutive attenders.

A further aim of our study was to ascertain whether different screening instruments identified different groups of patients. Our results suggested that they did, and we suspect that this would have been the case regardless of the precise screening instrument used in the study. The main point is that patients presenting to the emergency department with alcohol problems are a complex and heterogeneous group. Blanket approaches to treatment are unlikely to work and we need to target specific interventions to those patients who might most benefit.

As with assessment tools, a brief alcohol history was taken by the researcher interviewing the patients. The staff assessment consisted simply of the interviewer asking the member of emergency department staff who had seen the patient whether they thought the patient was alcohol related. The patient agreed with the staff assessment in just over one third of cases (29 of 76). There was a higher level of agreement between the patient and the CAGE assessment, with agreement in two thirds of cases (49 of 75). We would strongly support the use of any of these tools such as the PAT and the CAGE assessment for alcohol problems in the emergency department. However, for this to be a useful process to treatment are unlikely to work and we need to target specific interventions to those patients who might most benefit.

The Manchester APLS manual first spoke to the world in 1993. Its highly practical approach proved to be extremely popular. Therefore, building on the feedback from the Advanced Paediatric Life Support Courses the manual began to walk with the publication of its second edition in 1997.

The manual is now ready to start school and interact with other organisations. The 3rd edition has affiliation with the European Resuscitation Council, the Resuscitation Council of South Africa and Australian Advanced Paediatric Life Support Course. This latest edition has undergone some refinement. The initial two parts of the manual have had only minimal revision bringing them into line with current resuscitation practice and add further practical advice such as the use of semi-automatic defibrillators in children. The main revision has been in the seriously ill child section. Chapter headings have been changed to reflect the presenting problem of children. Layout and presentation of this section has changed dramatically.

The final sections on trauma and practical procedures have had only minimal alterations. It is noteworthy that with the affiliation to Australia, an additional appendix has been added dealing with the Australian system of triage.

In general terms this continues to be an excellent practical manual for resuscitation of children in the first hour. I have frequently been faced with junior doctors in the resuscitation room of the local Accident Hospital with the APLS manual open correcting my actions!

There are some disappointments with the new text. As with a child starting school, there is an inordinate amount of spelling and grammatical errors contained within the new sections. While these seldom directly affect the understanding of the main text, they are extremely irritating. I have mixed feelings about the revision to the serious illness section. While there is much more information contained within the chapters compared with the 2nd edition, the revisions have made the chapters less easy to read and more like a standard textbook. There is also an excessive amount of repetition in each of the chapters.

However, these are minor quibbles in a text which has become the gold standard for paediatric resuscitation in the UK.

The strength of the APLS manual has been that it is available to buy without actually undertaking the course. It is also continually updated by feedback from individuals undertaking these courses. The manual will continue to grow and reflect changing patterns of care in paediatric emergencies. Long may it continue.

J Ferguson

References
obviously aimed at developing countries but I would recommend that this book find a place in all NHS hospital libraries. Perhaps when junior doctors in the United Kingdom are feeling overworked and consultants believe that they are underpaid a review of this reference text would lead them to ponder on their good fortune.

J P Beavis

Key topics in accident and emergency medicine, 2nd edn

This is the second edition of a book that will be already familiar to most trainees and consultants in emergency medicine. Speaking from personal experience this excellent text indexed related topics are given at the end of each chapter including web site addresses and many in A&E will be relatively unfamiliar with this important topic.

There are many areas in which this book is commendable. The chapters have relevant headings and follow a logical pattern. Flow diagrams are well presented. Protocols are documented and expanded upon. As such they will probably travel badly.

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Oscar Wilde, “The Canterville Ghost”, 1887 A good handbook should provide ready access to relevant information in a readable format. One might expect residents to carry it around in their pockets, referring to it with decreasing frequency as their confidence grows. Many published handbooks reflect the practice in a given unit, designed to be used in that unit with all the protocols for that unit documented and expanded upon. As such they will probably travel badly.

Eye know how

Ophthalmology is a tricky area for many staff in accident and emergency (A&E). There are few true ophthalmic emergencies but many semi-urgent conditions that could benefit from early diagnosis and treatment. Unfortunately, ophthalmology is increasingly being squeezed from the undergraduate curriculum and many in A&E will be relatively unfamiliar with this important topic.

“Eye know how” is certainly a catchy title for a book aimed at the non-ophtalmologist dealing with ocular problems. It claims to concentrate on the common complaints seen in primary care and A&E. The structure of the book has something to commend it as the authors have adopted a presentation led approach to ocular problems with decision trees to aid diagnoses. Unfortunately, these, as with the rest of the books content, appear to be based on the authors current practice and opinions rather than any published evidence. There are many areas in which this book is commendable. The chapters have relevant headings and follow a logical pattern. Flow diagrams are well presented. Protocols are documented and expanded upon. As such they will probably travel badly.

S D Carley

Handbook of pediatric emergencies, 3rd edn

“We have really everything in common with America nowadays, except, of course, language.”

Oscar Wilde, “The Canterville Ghost”, 1887

A good handbook should provide ready access to relevant information in a readable format. One might expect residents to carry it around in their pockets, referring to it with decreasing frequency as their confidence grows. Many published handbooks reflect the practice in a given unit, designed to be used in that unit with all the protocols for that unit documented and expanded upon. As such they will probably travel badly.

There are areas in which this book is commendable. The chapters have relevant headings and follow a logical pattern. Flow diagrams are well presented. Protocols are documented and expanded upon. As such they will probably travel badly.

Now, however, we come to Oscar Wilde (see above). This book is driven by North American practice, associated with North American phraseology, terminology and usage. Those of us who get most of our CME from watching "ER” and “Chicago Hope” will probably be familiar with much of the terminology (CGR, BUN, etc). While this is little more than an irritant it does detract from the relevance to United Kingdom practice.

I tried to gain some insights in to the management of some of the child abuse cases by delving into the book, after I had seen the patients. In the main I agreed with the principles of care described, but there were areas where I was not in agreement with the authors. I was particularly disappointed not to be able to find anywhere in the book a description of how to perform a femoral nerve block. Surely this would be much more important to include than fig 15.2 showing how to remove a foreign body from an ear?
How does this book fare? The clinical data are good, but the style (and North American slant in particular) detracts from its appeal on this side of the pond. Other than that, Oscar Wilde says it all!

T F Beattie

Injury control: a guide to research and program evaluation


This book aims to catalogue the research designs available for all those involved in injury control and research. It is aimed particularly at those who wish to improve their understanding, review injury research or conduct research in the field, so essentially it is a reference text. It is a hard backed book, 280 pages long, written by a group of epidemiologists and trauma surgeons from Harbourview Medical Center in Seattle.

To a large extent this book is successful in its aim. It has 20 chapters and begins with a historical review of what injury research has achieved to date. The future challenges of improved management for traumatic brain injury, multi-organ failure prevention and the measurement of disability are laid before us.

The first half of the book lays the baseline and describes injury scoring systems, the use of secondary databases, how to select the correct study design and issues such as sampling. Some of these first 10 chapters are useful, others, such as that on rates and epidemiological principles, lack worked examples that would have helped when explaining issues, such as the difference between direct and indirect standardisation and the different forms of regression analysis. This half of the book fails to acknowledge the contribution of physiologists and animal work. In general the book has a large epidemiological bias, reflecting the backgrounds of the contributors from either side of the Atlantic.

The second half of the book generally cuts to the chase and details the different types of studies available to those conducting research. There are useful contributions from either side of the Atlantic. Ian Stiell’s section on developing decision rules is particularly inspiring.

Despite its omissions this book is a useful reference text for those undertaking research in injury and those wishing to broaden their knowledge and understanding with some focused reading. Injury control needs a clinician’s as well as an epidemiological perspective.

F Lecky

999 EMS Research Forum Board

The 999 EMS Research Forum Board is accepting abstracts for presentation at AMBEX 2002. Papers are invited on all areas of prehospital emergency healthcare. Papers for consideration should be submitted by 6 May 2002.

To obtain an official submission form email Anne Surman at a.g.surman@swan.ac.uk or write to Anne at the Clinical School, University of Wales Swansea, Singleton Park, Swansea SA2 8PP.

Submissions

Authors of the most original and interesting scientifically based work in the prehospital arena will be invited to present their study in either an oral or poster presentation during sessions at AMBEX 2002.

All work must be original and must not have appeared in a national journal or have been presented at a national meeting prior to the submission deadline.

All abstracts accepted by peer review will be published in the Emergency Medical Journal.

Awards

Cash awards will be given for:
- research most likely to impact on patient care
- most original research
- best poster

CORRECTION

An editorial error occurred in this article by Tewary and Cawte (January 2002; 19:81). The illustration was used by permission from Disney Enterprises, Inc. We apologise that this statement was omitted from the article.