Calcium for hyperkalaemia in digoxin toxicity

In their article on the management of hyperkalaemia1 Dr Alhe 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)2 that calcium administered in the setting of digoxin toxicity will probably induce arrhythmia or cardiac arrest. Immediate reversal of digoxin toxicity with digoxin antidote will be taken 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 commonly held belief in the A&E department—that a double Tubigrip or another 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 measure in 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 commonly held belief in the A&E department—that a double Tubigrip or another 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.

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.1 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 commonly held belief in the A&E department—that a double Tubigrip or another 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.

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In conclusion, this study is limited by the reluctance of patients to consider a treatment preference. However, given the importance of patient satisfaction, it would be helpful to include this measure in future studies.

References

Author’s reply

We thank Miss Mason for her comments on our paper.1 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 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.

References

B Watts

References

Table 1

<table>
<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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</tbody>
</table>
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 visual acuity testing a few weeks after such an injury 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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Reference


Tuberculous osteomyelitis

Yuen and Tung describe a case of tuberculous osteomyelitis in a foot ulcer and 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 estimations of sensitivities. 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 for use, particularly if the clinical findings are subtle or atypical.

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References


Authors' reply

We thank Dr Ho for his comment on our article reporting a young patient with tuberculous osteomyelitis. We wrote the article from the perspective of emergency medicine. Although polymerase chain reaction (PCR) is a good adjunct to microbiological culture for diagnosing mycobacterium tuberculosis, it is not available to the majority of emergency physicians in Hong Kong. None the less, we should discuss it briefly so that our article is more informative to readers.

Without argument, PCR provides an opportunity for early diagnosis and treatment. However, we should also note the limitation of the PCR especially when the PCR result is negative.

In 1998 Shah et al reported the accuracy of the AMPLICOR PCR test in diagnosing mycobacterium tuberculosis in tissue and body fluid specimens. In this study, culture proof was adopted as the gold standard for diagnosing tuberculosis. Although 1032 patients were included in this study, only 34 specimens were positive for tuberculosis. Therefore, the sample size was too small and the 95% confidence interval of the sensitivity was too wide to suggest that PCR would not miss the diagnosis of mycobacterium tuberculosis. In this study, the PCR had a sensitivity of 76.4%, a specificity of 99.8% when results were compared with the gold standard. With the high specificity, PCR is a good “rule in” test. However, PCR should not be used as a “rule out” test because of the high false negative rate.

In 2000 Lim et al reported the accuracy of the AMPLICOR PCR test in diagnosing pulmonary tuberculosis in smear negative respiratory tract specimens. Again, the PCR test had a low sensitivity of 44% and a high specificity of 99%.

With evidence from both studies, a positive PCR test result facilitates early diagnosis, but a negative PCR test result cannot exclude mycobacterium tuberculosis. At the moment, microbiological culture remains the gold standard for diagnosing tuberculosis and a high index of suspicion for tuberculosis is the key to diagnosis.

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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 this 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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www.emjonline.com
Table 1  Frequency of journal review

<table>
<thead>
<tr>
<th>Journal</th>
<th>Reviews per year</th>
</tr>
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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>
</tr>
<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>Resuscitation</td>
<td>2</td>
</tr>
<tr>
<td>Anaesthetic journals (Anaesthesia, 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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</table>

References


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 radiology, but the importance of taking a good 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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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 study1 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,2 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 staff.

Studies suggest the CAGE detects dependent rather than hazardous drinkers,3 a point rightly discussed by Haddad et al, and emphasised elsewhere.4 Compared with dependent drinkers, hazardous drinkers (earlier on in their drinking history) are more likely to respond to brief interventions.5

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.1 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.”2 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.1 As Huntley et al point out, this may reflect the fact that we effectively had an extra member of emergency department staff on duty. It is possible that we would have had a much lower compliance rate if we had 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 regards 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 attendance 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 a further agreement in two thirds of cases (49 of 75).

The Manchester APLS manual first spoke to the world in 1993. It has experienced a very high level of usage in terms of the number of units to which it has been added. The latest edition has undergone some refinement. The authors state that this has resulted in the manual having had only minimal revision bringing it 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 drastically. The final sections on trauma and practical procedures have had only minor alterations. It is noteworthy that with the affiliation to Australia, an additional appendix has been added dealing with the ATLS system which has become the gold standard for paediatric emergency care.

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 our local 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 manual, 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, there 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 undergoing the course. The manual will continue to grow and reflect changing patterns of care in paediatric emergencies. Long may it continue.

J Ferguson

References

Save lives, save limbs

“Save lives save limbs” by Hans Husum and his colleagues is a book that is attractive, full of information, and, although at times it reads like a heart tugging novel, retains high educational value. In a concise and well illustrated manner the book describes the total care of the victims of anti-personnel weapons. It should appeal to everyone interested in humanitarian aid and, in my opinion, to those who find themselves working outside the luxurious resources of Western hospitals. The authors have substantial experience of working in adversity and they try to offer a solution to the inadequate resources usually found where most of these injuries occur.

It begins with a well illustrated description of the types of mines and the injuries they produce. The description might leave some wonder what sort of person actually sits down and designs these ghastly devices. Perhaps even more amazing is the thought that many highly respected members of Western communities live well on the profits from this lethal trash.

ATLS techniques are described in detail and there is an excellent theme of damage control in trauma care. Technical details are supported by the simple principle that everyone involved can learn the basic techniques of life and limb preservation and once learnt it is our duty to pass on the knowledge. The simple statements and clear illustrations, often in cartoon form, prove that the authors themselves followed this ideal and urge the concept of the “Village University”.

There is an academic quality to this book as well. Practical advice on prehospital care, surgical techniques, anaesthesia, and nutrition. The physiological importance of fear is emphasised with an example of how to calm a patient while organising their removal from a minefield—a vital but common form of prehospital care in the real world. Every subject is illustrated by, inspiring, examples of ordinary people—some qualified in medicine or nursing and others not—who have saved life and limbs by using their skills.

Trauma specialists are no use if they are three days travel away from the casualty. The possession of higher surgical qualifications at a distance count for nothing compared with limited but immediately. An impressive proof of this fact is the use of limited laparotomy when isolated from a major hospital. The book describes how to stop bleeding and leave the complex visceral repair to the “experts” after transfer. There is an excellent example of an Afghan nurse successfully undertaking imperative “damage control” laparotomy for intra-abdominal bleeding; movement of the casualty to a hospital was too dangerous and not possible because of the likelihood of aerial fighter attack during daylight hours! Quite possibly this type of treatment would lead to a reduction in the incidence of the increasingly recognised “abdominal compartment syndrome”.

Very few engaged in trauma care would fail to gain some new knowledge or insight from this excellent, “one sitting read”. Despite its simple format the book is an excellent text for UK trainees and demonstrates universally applicable methods while using common sense to underline theory.

The book confirms that “knowledge is power”, especially when it is shared. It is...
Resuscitation in primary care

I have a thing about “whinging” GPs (despite the fact that my three children believe that it is me). I get really irritated by the person who stands up at a clinical meeting and tells his hospital colleagues “that’s all right for you in your ivory tower, but out there in the real world”. So when I saw this book I thought is this another attempt by primary care to demon- stronstrate its need to be independent of our hospital colleagues? We have an excellent Advanced Life Support Manual that the Resuscitation Council—why do we need this? Then I sat down, took my cine’s hat off, and looked at the situation once again. I got out my Advanced Life Support Course and looked through it and thought to myself—I do not carry adenosine. Blood gas analysis in the patient’s room is a tricky procedure, the cardiac arrest team is usually me and an ambulance crew as well and post resuscitation care consists of getting the patient to hospital as quickly as possible—with ventilatory support if necessary.

There are significant sections of the Advanced Life Support Manual that are not relevant to GPs and therefore there probably is a need for a book about resuscitation in primary care. I could now spend the next two or three pages giving you reasons why The Resuscitation Council should think about an ALS Course—specifically for out of hospital practitioners. I will resist the temptation—it may however be worth thinking about.

“Resuscitation in primary care” not only goes over all the relevant material with regard to prehospital cardiac resuscitation but also covers resuscitation of infants, children, and the newly born—in my experience areas that give rise to a lot of worries in prehospital care practitioners. It does all this in 132 A5 size pages of reasonably large type therefore it is not a long read. It contains all the European Resuscitation Council Algorithms relevant to Pre-hospital care Resuscitation and covers all the aspects of resuscitation in relevant detail and also covers anaphylaxis. Therefore this book could easily be used as a manual for a prehospital ALS course.

My only criticism would be the method of presentation. I would save up a little longer for a text book and would recommend that this book find a place on the shelf of every prehospital care practitioner. I will resist the temptation—it may however be worth thinking about.

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 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 logical and relevant to most practices, as are the references at the end of the chapters and sections. These, however, have a significant bias to North American publications, ignoring publications from other geographical areas. Is their Medline different to ours?!

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 (CPR, 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 children attending my unit by delving into the book, after I had seen the patients. In the main I agreed with the principles of care described, but there are areas where I would disagree 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

NOTICE

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.