Use of cut endotracheal tubes should be avoided in the initial resuscitation of the burned patient

The use of cut endotracheal tubes is already a contentious issue amongst anaesthetists. We wish to point out a potentially life-threatening hazard when they are used in the emergency department during the initial resuscitation of the thermally injured patient.

Often these patients are intubated early if there is any indication of inhalational injury or facial burns. This is because subsequent oedema of the face and larynx can compromise the airway and render intubation difficult or impossible.

If a cut endotracheal tube has been used to secure the airway in this situation and there is subsequent facial or airway swelling, the proximal end of the endotracheal tube may become dislodged from the larynx. At this stage, it may be extremely difficult to reintubate the patient or exchange the tube for a longer one. Often these patients are intubated early if there is any indication of inhalational injury or facial burns. This is because subsequent oedema of the face and larynx can compromise the airway and render intubation difficult or impossible.

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As a tertiary referral centre for burns we often receive patients directly from emergency departments. This is because subsequent oedema of the face and larynx can compromise the airway and render intubation difficult or impossible.

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contrast between the roles and the relationships of emergency physicians and anaesthetists on either side of the Atlantic. These differences are most usefully seen as a trigger for reflective debate rather than as a reason to view the book as not applicable to UK practice. It most certainly is applicable to UK practice and would be useful reading for every trainee in anaesthesia, ITU, and accident and emergency.

A McGowan
St James’s University Hospital, Leeds, UK

The clinical practice of emergency medicine, 3rd edn

While it is often said that those that can, do, and those that can’t, teach, one gets the impression that the authors of this textbook not only work at the “coalface” of A&E medicine but also teach with authority. The wide ranging subject material is approached from the more clinically relevant “presenting complaint” viewpoint rather than the usual diagnostic categories, giving an exceptionally practical orientation to the book. Essentially a reference book it enters a competitive market but offers a far more readable format than its main rivals to provide a balanced and accessible view of the dangers of childhood. While not wishing to minimise how great these are, it is also true that books such as these can scare parents, grandparents, and carers into timidity themselves and an inability for their charges to explore or have any fun.

Child safe: a practical guide for preventing childhood injuries

Child safe is a book officially endorsed by the American Academy of Emergency Medicine written by a doctor who is a practicing emergency physician in a trauma emergency centre in Tulsa, Oklahoma. It is written for the non-medical audience and draws on the author’s considerable experience of trauma and illness in childhood. It is suggested reading for parents, grandparents, and carers of children.

The book is divided into two main sections termed “Non-age related injuries”, which includes falls, burns, and scalds, and “Age related injuries” including infants, toddlers and preschoolers, and school age children and the types of injuries that specifically befall them. The third part is a list of American product recalls and child safety resources such as the Farm Safety Association.

Although a lot of the general points are made well, there are two main problems with the book. The first is that this is essentially a book for an American readership concerning American products and relating to the American healthcare system. Therefore, it would be of less value in Europe. The second is the negative tone throughout the book rendering any spontaneity or adventure in childrearing almost impossible.

It is a book to be read in conjunction with Swallows and Amazons to provide a balanced view of the dangers of childhood. While not wishing to minimise how great these are, it is also true that books such as these can scare parents, grandparents, and carers into timidity themselves and an inability for their charges to explore or have any fun.

In short, a book to read but possibly not to re-read, for every zealous parent.

This book is intended for carers and is not a required addition for a medical library or for the EMJ readership.

D Hulbert
Emergency Department, Southampton General Hospital, Southampton, UK

NOTICES

Reducing waits in A&E: search for evidence

The University of Warwick are conducting a systematic literature review of the evidence for interventions aimed to reduce waiting time (total time in A&E, wait for a doctor, wait for results, wait for admission, “trolley wait”) and attendance in accident and emergency departments. This project is funded by the Department of Health. If you have undertaken any such innovations and have audited or evaluated the changes (or are aware of anyone who has done so) then please contact Dr Matthew Cooke, Project Lead, Centre for Primary Health Care Studies, School of Health and Social Studies, The University of Warwick, Coventry CV4 7AL, UK; m.w.cooke@warwick.ac.uk.

Medic 1 Trust Fellowship

The Medic 1 Trust Fellowship is awarded to facilitate education or research in the field of accident and emergency medicine and may be used for associated travel. The fellowship is awarded to a doctor or nurse currently working in the field of accident and emergency medicine. The value of the award will be a maximum of £2500. A maximum of one medical scholarship and one nursing scholarship will be made every year. Applications must be received by 28 February 2003. For further information, please write to: Chairman of the Medic 1 Trust, c/o Maclay Murray & Spens Solicitors, 151 Vincent Street, Glasgow, G2 5NJ.