We felt that another factor may be changes to the GP contract in 1995. GPs no longer have to visit all who call but can use their clinical judgement and can telephone for an emergency ambulance without seeing the patient or can advise the patient or carer to do so. In particular, the change in contract has stimulated the growth of GP cooperatives to cover urgent calls and has been related to the change in contract has stimulated the growth of GP cooperatives to cover urgent calls and some 10.9% of the increase in urgent calls. We have not investigated the reasons for this change in practice but emphasis on the early recognition and treatment of severe asthma, myocardial infarction, and meningococcal disease may have stimulated many patients to call for an ambulance rather than phone their GP.

You would expect a rising emergency workload to cause an increase in both 999 calls and in calls to the GP that would result in more urgent transfers. This has not happened and it seems that there has been a transfer of some work from the GP services to the ambulance service. Some 10.9% of the increase in emergency calls can be accounted for by a decreased number of urgent calls.

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Urgent calls fell from 42.8% to 30.2% of the total acute workload. The increase in the emergency work of the ambulance service is of particular, the change in contract has stimulated the growth of GP cooperatives to cover urgent calls and some 10.9% of the increase in urgent calls. We have not investigated the reasons for this change in practice but emphasis on the early recognition and treatment of severe asthma, myocardial infarction, and meningococcal disease may have prompted patients to call for an ambulance rather than phone their GP.

Many of the transferred workload may be justified but it has a cost. For the ambulance service, urgent calls have to arrive at hospital within half an hour of the time specified by the GP whereas emergency calls have to be responded to within eight minutes if category A and 19 minutes for category B. Emergency patients need to be assessed by a paramedic whereas for urgent calls, much of the assessment will have been done by the GP. For the hospital, patients arriving as a result of urgent calls will be seen by the admitting team. The same patient arriving as a result of a 999 call will need to be assessed by an A&E doctor before referral to the admitting team and this is putting additional pressure on A&E departments.

Prehospital thoracotomy

We were interested to the read case report by Wright and Murphy of a prehospital thoracotomy.1 We use a rather different interpretation of the evidence to guide our approach to this problem. We differ on a number of points. If an immediate prehospital thoracotomy is indicated, we have learned from the nine survivors that have been achieved within the London HEMS system, that arrest is not an indicator of an unsurvivable injury. We would also disagree with the time limits given for this intervention, and would only recommend a prehospital thoracotomy when the “down-time” is less than 10 minutes—30 minutes of zero cardiac output makes this, or any other intervention, futile.1 It is also incorrect that all survivors of this procedure are neurologically intact—it should be expected that there will be a level of brain injury associated with “near death”. There is insufficient evidence to be definite about the incidence of disability in survivors but current evidence would suggest that prehospital thoracotomy has about the same long-term disability as emergency room thoracotomy (around 10%).

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References


Author’s reply

I thank Davies and colleagues for their interest and comments. I should like to address some of their questions.

This was a case report.1 It did not attempt to lay down protocols for use based on such a limited evidence base. The important learning points from this case should be:

Figure 1 Emergency and urgent calls to Westcountry Ambulance Service, 1994–2001.
(1) The simple technique and the lack of specific cardiothoracic instruments or expertise.

(2) The fact that spontaneous motor activity and evidence of cerebration may occur in this group will certainly associate with a significantly worse outcome and thoracotomy in this group will certainly where we should aim but response time or there may be delays in obtaining limb ultrasound can be used to help confirm the clinical suspicion of long bone fracture in pregnancy has also been described. Although ultrasound has been used to guide placement of regional nerve blocks electively, there are no reports of this use in the ED setting.

The cases presented illustrate how ultrasound can be used to help confirm the clinical suspicion of long bone fracture in the trauma or resuscitation room. Often the trauma patient may be haemodynamically too unstable for transfer to the operating department, or may be delays in obtaining limb radiographs. Confirmation of femoral fracture permits early planning for traction splint application and contributes to the resuscitative process.

The accurate placement of a femoral nerve block in this clinical setting also offers significant benefits for the patient. The traditional method of using a nerve stimulator to locate the femoral nerve can be extremely painful for the awake patient with a femoral fracture (personal observation), yet the blind introduction of local anaesthetic into the femoral region risks ineffective nerve block. Ultrasound offers a non-invasive, painless method of identifying the local anatomy, specifically the femoral vein and artery. The introduction of local anaesthetic lateral to the femoral artery can then be visualised directly, increasing the likelihood of effective block.

References

Use of emergency department ultrasound in the diagnosis and early management of femoral fractures

We describe two cases illustrating the use of bedside ultrasonography in the trauma room, to confirm femoral fracture, and to guide accurate placement of femoral nerve block.

Case 1
A 13 year old boy was brought to the emergency department (ED) by ambulance. He was undergoing leg lengthening surgery and had an external fixation device attached to his left femur. He had fallen onto his left knee at school, with subsequent pain and inability to bear weight. There was a tender swelling over the lateral supracondylar area of his left femur, with severe pain on minimal movement. Bedside ultrasonography in the ED was used to confirm the clinical suspicion of a distal femoral fracture. Ultrasonography was then used to image the anatomy of the femoral vessels in the left groin permitting identification of the correct location for placement of a femoral nerve block.

Case 2
A 39 year old female pedestrian was brought to the ED by ambulance having been struck by a car while crossing a road. She was alert and complained only of pain above her right knee. Her vital signs were stable. After major trunical injury had been excluded, including the use of focused assessment by sonography in trauma (FAST), ultrasound imaging was used to confirm a distal femoral fracture (fig 1). The patient complained of severe pain despite large doses of morphine. Again ultrasound was used to locate the correct position for femoral nerve block (fig 1) providing sufficient analgesia to permit application of a traction splint and subsequent transfer for definitive radiographs.

Bedside ultrasonography is being used increasingly by emergency physicians and trauma surgeons in the ED. The FAST scan has become common practice in many trauma centres and has been shown to be accurate in detecting intraperitoneal haemorrhage.1 The use of ultrasound in the diagnosis of long bone fracture in pregnancy has also been described.2 Although ultrasound has been used to guide placement of regional nerve blocks electively, there are no reports of this use in the ED setting.

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References


BOOK REVIEWS

Emergency ophthalmology: a rapid treatment guide


Pardon the pun, but ophthalmology is a very visual topic, so any book that aims to help the reader identify and treat eye emergencies relies on liberal use of colour photographs to permit rapid correlation between the patient in front of you and the relevant chapter. In this respect, Emergency ophthalmology does not disappoint. Furthermore, the editor, himself an assistant professor in the specialty in Boston, has drawn on a wide and expert body of authors to add authoritative guides to the immediate management of many common and not so common eye emergencies. A cynic might observe that none of the authors is himself an emergency physician, but in reality this is of little consequence—can you honestly say you aren’t relieved to refer horrendous eye problems to someone who knows more about it than you?

The structure of the book is logical. A detailed summary of the anatomy of the eye and orbit, together with a reminder of how to examine the visual system properly, leads into a series of well illustrated chapters that take each component of the eye and orbit in turn and give clear details regarding the management of a wide range of pathology. Like any decent picture book, it is a pleasure just to flick through the colour photographs even without a patient to treat.

Some sections of this book are obviously more relevant to emergency medicine than others. In particular, the (brief) sections dealing with squints and some of the more esoteric visual tests available struggle to hold the reader’s interest. There is also the issue of this being an American text, with the usual differences in drug nomenclature and certain aspects of ongoing care, but it is quite clear where these occur and there is no great problem in translating the information to UK practice.

There is always a sting in the tail with books that rely heavily on colour illustrations to make them worthwhile—the cost. I couldn’t find any web site that sells this volume for less than £44, which makes it a departmental investment, and to be fair, there would be little point in buying this book for individual use. Having said that, this compact and very readable book contains a wealth of helpful information and would be a useful addition to any library.

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Neurological emergencies, 3rd edn


Neurological emergencies are comparatively rare but can have disastrous consequences if missed or mismanaged. Neurology terrifies many SHOs and even the most experienced specialist is likely to feel nervous at the thought of a patient with myasthenic crisis or cerebral malaria. A text providing up to date, practical information on the diagnosis and differential diagnosis and treatment. How-ever, the chapter on acute spinal cord compression suffers from having too much detail on different surgical procedures and not enough on immediate assessment and management. Additionally, the first chapter on medical coma is, to be blunt, poor. I suspect that while its author may be an eminent neurologist, it is a long time since they saw an acute patient. A lot of the information, especially on poisoning, is outdated and some of the management recommendations are rather suspect.

I was disappointed that apart from the chapters on traumatic brain injury and acute stroke, the other chapters are practically word for word the same as in the second edition. The cover of the book promises it “has been thoroughly revised and updated…” however there is not enough evidence of this to make it worth buying the third edition if you already have the second edition.

Despite the above criticisms, overall the book is interesting, and the contributions well written. It is a useful, concise reference text to have in the department and is particularly good for preparing teaching sessions or revising for the MRCS (A&E) or FFAEM exam as all the necessary information about pathophysiology, differential diagnosis, and investigation is there. I would recommend it to A&E specialists to be read at their leisure. However, it is not a practical handbook and not something you would consult when faced with an acutely sick patient.

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