Are accident and emergency senior house officers getting slower?

You sometimes hear people saying that senior house officers (SHOs) in emergency departments are not what they used to be. We studied data collected over a five-year period (1996–2001) on the number of patients seen by all SHOs who completed a six-month post in our A&E department.

The 118 SHOs (62 male and 56 female) worked a full shift rota averaging 52 hours per week. The influence of the sex of the doctor and their future career plan on the number of patients they saw was also assessed. The number of patients seen by each SHO in six months ranged from 1069 to 2659 (mean 1774, SD 346). On average the SHOs worked a six-month post in our A&E department.

Among the substances included in the final analysis, clearly tricyclic antidepressants (TCA) are of greatest concern. However, the electrocardiogram may be a better prognostic indicator of TCA poisoning, and may be a more sensitive indicator of drug presence than drug concentrations.1 In addition, it is our belief that acetaminophen is the only drug screen that has been shown to have a clinical impact in intentionally self-poisoned patients.2

The diagnosis and management of the self-poisoned patient is centred on a careful history and physical examination. Directed adjuncts such as an ECG and acetaminophen concentration may influence management and disposition. We would caution against the use of broad testing of the self-poisoned patient as a guide to medical decision making. Even if this technology was widely available and economically viable, we question its utility as, in most cases, it is unlikely to affect the management of the self-poisoned patient.3

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What is “relative analgesia”?

I welcome the paper by Frampton et al describing their experiences of nurse administered nitrous oxide, which adds further evidence to the literature supporting this technique as a useful and safe method of easing the suffering of children during their attendance at an emergency department.

I feel that the use of the term “relative analgesia” is somewhat confusing; this is not a term previously encountered in the literature describing sedative/analgesic techniques. The United States guidance (their reference 2) does not use this term when defining sedation levels nor do the current UK5 and Australasian6 guidance and definitions. To introduce a new term may prevent accurate comparisons of techniques in the literature.

I would also welcome description of two other outcomes measured. Nurses would find important when considering a sedative/analgesic technique: adequacy of sedation and parent/observer satisfaction. The authors do describe 10 cases (4.4%) requiring additional sedation but not specifying how many children were adequately sedated, or inadequately sedated but the procedure was completed anyway. Nitrous oxide has two useful properties: analgesia and sedation. In the context of this study “relative analgesia” could mean “inadequate analgesia” or “sedation (without analgesia)”.

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References


Authors’ reply

Howses’ concern about the term “relative analgesia” pertaining to our recent description of nitrous oxide analgesia in children is noted. This is actually a term that has been used to describe nitrous oxide analgesia for many years. It first appeared in the dental literature and was used originally to describe situations where continuous flow/variable concentration nitrous oxide was administered, often via a nasal mask.7 Other authors looking at the risk of aspiration using nitrous oxide analgesia used the term “relative...
analgesia" when studying 50% nitrous oxide/oxygen (Entonox)." The term does not appear to have been used in any of the emergency medicine literature pertaining to nitrous oxide that we have seen.

The term continues to be used in contemporary literature " and in 2001 Lahoud et al. described relative analgesia as having the effect to enable patient remaining conscious deliver 100% O₂ if needed. Certainly we found in our study that distraction techniques are easily done in conjunction with this method of analgesia and form an important part of it. We have used the term "relative analgesia" in our institution for many years, which is why it was included in our study. The term has also persisted in the name of the equipment used to administer continuous flow/variable concentration with the Quanti-flex RA machine originally manufactured by Cyprane, Keighley, England and now by Matrix Medical, New York.

We agree with Howes that there is enough confusion in the semantics of the literature on sedation/analgesic techniques without rejuvenating old terminology. However, perhaps the term "relative analgesia" may be useful in describing analgesia by inhalational techniques alone, which are becoming more common using agents such as nitrous oxide, methoxyflurane, and nitrous oxide/sevoflurane mixtures. Nitrous oxide provides analgesia, amnesia, and mild amnesia obtained with maintenance of verbal contact and predominantly intact laryngeal reflexes. No other single agent does this.

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References


Climbie Inquiry sets new standards

King and Reid' highlight a number of standards relating to child protection procedures within emergency departments. In January 2003, Lord Laming published his report of the Victoria Climbie Inquiry which contains further recommendations regarding healthcare arrangements for children and procedures for investigation of possible deliberate harm. Those relevant to emergency department practice mainly concern administrative standards, such as recording the name of the “primary carer” for each child attending the department and obtaining information on previous attendances at other hospitals when concerns about deliberate harm have been raised. The recommendations have various suggested timescales for implementation ranging from three months to two years from the publication date and we would urge all those involved with child protection to read the report summary (available at http://www.victoria-climbie-inquiry.org.uk/index.htm) and check that their practice complies with the recommendations.

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Reference


Steering wheel spin

Nigam and Cutter totally fail to present evidence to justify the claim that "Welsh emergency vehicles examined exhibited an unacceptable level of bacterial contamination". What is more, a press release from the editorial team to local newspapers led Madeline Brindley of the Western Mail to write, “Dirty ambulances infested with huge amounts of harmful bacteria are carrying seriously ill patients to hospital in Wales, according to a report published today. The new research discovered that even after they have been cleaned, ambulances are still home to "unacceptably" levels of bacteria.”

The authors make no attempt to quantify levels of bacteria for any given measured area. However, our work was simply described as a preliminary investigation and this pilot study did identify shortages in cleaning practices in use at the time of the study. These included a lack of designated cleaning equipment for ambulances, insufficient time for thorough cleaning, and lack of suitable decontamination processes for medical equipment.

Most organisms identified in the study were unlikely to pose any threat of infection to patients or ambulance personnel. This was clearly stated in our article, but sadly was often ignored in the subsequent press reports, resulting in public concern.

Having identified that there were shortages in cleaning practices, action was required. The Welsh Ambulance Trust responded immediately to the results of the study and, supported by one of the authors (JC), took action to improve standards of cleanliness. This included the following:

• The Infection Control Committee and Regional Infection Control Teams continue to monitor cleanliness through regular environmental audits;
• Colour coded cleaning equipment has been introduced to prevent cross contamination during cleaning and standardisation of detergents and disinfectants has been completed;
• All vehicles have now been provided with "spillage kits" to absorb fluid spills;
• A chlorine releasing disinfectant is provided for each vehicle for prompt decontamination of blood and body fluids;
Significant investment has been made to replace re-usable medical equipment, for example, Entonox masks and suction canisters with disposable alternatives. Disposable covers are provided for laryngoscope blades and single use bougies for intubation have been supplied;

Infection control training is provided during all patient transport services and emergency technician training courses in which the importance of cleaning is included.

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Children and mini-magnets: comments and suggestions

I read with interest “Children and mini-magnets’’ for I had previously listed similar events. The authors illustrate the difficulty of separating attracted magnets when avoiding further trauma to the entrapped tissue, as the usual methods—of sliding the magnets apart, or using standard instruments—cannot be used. It is possible to “short out” the effective strength of a magnet (in the same way that the soft iron keeper of a horseshoe magnet greatly diminishes its external attraction) by putting a high permeability material between the poles. One such material is “Permalloy”, and pieces and sheet can be formed around a magnet. (McCormick et al do not seem to list the magnetisation directions in the shape they encountered, so one cannot make any more specific suggestions.) Permalloy might be available in your friendly neighbourhood physics department. Another technique is to put a third similar magnet against one of the two problem ones.

Here in the USA, powerful magnets are used to hold ear “rings” or ear studs in place. A friend, who has given magnetic jewelled studs as science encouragement to pre-teens, has received thanks from their mothers: the mothers emphatically prefer the magnets to surgical ears.

I am curious about the origin of the Sheffield magnets: extremely powerful ones are found in discarded computer hard drives, but they have irregular shapes.

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Radiology in paediatric cervical spine injury

I read with interest the letter by Smart et al regarding the assessment of paediatric cervical spine injuries. It would certainly appear that many children in their cohort were radiographed unnecessarily according to current guidelines. However, I would hope that the practice in their institution has changed dramatically in the six years since the group attended. Current guidelines on selection of patients for imaging are based primarily on adults. In the NEXUS group, only 30 children had a cervical spine injury, and in the Canadian c-spine group, there were no children at all.

Extrapolating the results to children who may be distressed or uncooperative should be performed with caution.

The low prevalence of cervical spine injuries in children makes guidelines difficult to create. In an 11 year analysis of the Trauma Audit Network Database, only 239 children (of 19 538 with major trauma) were identified as having a cervical spine fracture and 21 with spinal cord injury without radiological abnormality (unpublished data).

I am concerned that the authors feel that a single lateral projection should be adequate. The evidence for omitting the PEG view is based on small case series or questionnaires, and certainly the odontoid synchondrosis should be ossified by the age of 7.

Imaging of the paediatric cervical spine remains a difficult problem. As the authors confirm, there is no substitute for adequate clinical assessment, but where this is not possible, every effort should be made to rule out a potentially devastating injury.

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References


Emergency department investigation of deep vein thrombosis

Kilroy et al should be commended for highlighting the difficulty of point of care (“near patient”) testing in general, and in emergency medicine in particular. They, however, failed to highlight some important points that may have been significant confounding variables in this study. Firstly, the authors quite rightly pointed out the qualitative nature of the SimpliRED (DD) assay and the inherent possibility for interobserver variation. Although this is a “simple” assay and comparatively accurate in experienced hands, there is a learning curve in performing and interpreting the results that the authors failed to emphasise. How steep or otherwise was the learning curves of the doctors assessing the SimpliRED test? The robustness of the data and the manual process for interobserver reliability was measured, for example by k and weighted κ statistics. Secondly, cut off points are critical in diagnostic testing because they determine the assay sensitivity or specificity. For example, if the DD cut off is set too low, then the test is too sensitive and not specific, so almost everyone ends up being positive and the test loses meaning. What was the cut off value for DVT diagnosis in this study? Was it based on receiver operator characteristic (ROC) curves (a scientifically valid method of determining diagnostic cut off values)? Differences in cut off values may explain the differences observed in the diagnostic performance of the assay in this study and Wells’ original data. Finally, to ensure good applicability, when choosing a DD assay it should be verified that the assay has been studied in a patient population similar to that in which it would be used. Did the authors extrapolate a cut off point for DVT diagnosis from the manufacturer of the assay? If so, was their study population similar to that of the manufacturer’s?

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Fractured clavicle and vascular complications

A 55 year old right handed man presented with a three month history of left arm pain and precordial chest discomfort. His symptoms had started three months previously after a heavy game of squash. Three years before the acute episode, he was involved in a motorcycle accident and had sustained a left mid-clavicular fracture.

On clinical examination he was in sinus rhythm and the supine blood pressure was 146/94 mm Hg in the right arm. He had a cold left arm with no recordable blood pressure. The left axillary, brachial, and radial pulses were absent. A bruit was audible over the left subclavian artery. The fasting total cholesterol was 4.4 mmol/l.

The chest radiograph showed non-union and displacement of the fragments of the left clavicle. Three dimensional contrast enhanced magnetic resonance angiography (CE-MRA) showed a small false aneurysm (diameter 1.5 cm) in the mid-portion of the left subclavian artery (see Fig 1). In addition there was a stenosis of the left subclavian artery adjacent to the aneurysm with an intraluminal thrombus, immediately distal to the point of stenosis. The aneurysm probably resulted from insult to the subclavian artery by the clavicular fracture and aggravated by squash playing.

Percutaneous balloon angioplasty with stent deployment to the left subclavian artery was attempted. The procedure was complicated by acute thrombosis requiring intra-arterial thrombolysis with streptokinase. Restoration of blood flow was achieved by a reverse vein graft bypass between thoraco-acromial and brachial arteries.

Injury to the subclavian artery should be considered in all patients who complain of ischaemic symptoms in the arm after clavicular fracture. Furthermore, this case...
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Atypical antipsychotics not recommended for control of agitation in the emergency department

We read with concern the article by Yildiz et al, regarding the recommended use of atypical antipsychotics for the control of agitated patients in the emergency department. Our concern rests mainly with the control of agitation secondary to drug ingestion, particularly sympathomimetic drugs of misuse (coca, MDMA “ecstasy”, and amphetamines), and antidepressants (SSRIs, tricyclic antidepressants, MAOIs).

It can be difficult to distinguish with certainty, the diverse aetiologies of acute confusion/agitation, and therefore the sedative agent of choice should be safe and effective regardless of the cause. In patients presenting with drug induced agitation, or when the aetiology of the agitation is not established (particularly in teenagers and young adults), the use of atypical antipsychotics such as risperidone, ziprasidone, olanzapine may result in adverse drug reactions, including serotonin syndrome, neuroleptic malignant syndrome, QT prolongation and subsequent ventricular arrhythmias (including torsades de pointes), arrhythmias without QT prolongation, or extrapiramidal features including dystonic reactions.

In the setting of drug induced agitation, the National Poisons Information Service (London) strongly advocates the use of carefully titrated, lone benzodiazepine sedation.

This is because the benzodiazepines (for example, diazepam, lorazepam, and midazolam) are well tolerated, with a high therapeutic index, and are not implicated in any of the above reactions. They have proved safety and efficacy in animal experiments and widespread clinical use for sympathomimetic drug related agitation. They also possess dose dependent efficacy that is easily titratable, and have established seizure prophylaxis and seizure terminating activity. Benzodiazepines have no arrhythmogenic potential with therapeutic or toxic exposures, and antihypertensive and arrhythmia preventive activity in sympathomimetic drug toxicity, and proved efficacy (in a randomised, double blind, placebo controlled trial) in cocaine associated acute coronary syndromes.

We question why one would want to put an already unstable patient at risk of further harm with the use of potentially dangerous atypical antipsychotics, when an established safe, efficacious, rapidly acting, cheap alternative (benzodiazepines) is readily available?

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References


Nothing ever changes...

Readers may be interested in the following abstract from the Lancet of October 1869, “The Lancet investigation into the administration of the out-patient department of the London hospitals”.

On the morning in question, 120 patients were seen and dismissed in an hour and ten minutes, or at the rate of 35 seconds each. Who shall say what mistakes were made? None can tell....they are dismissed with a doubtful dose of physic, ordered almost at random, and poured out of a huge brown jug, as if the main object were to get rid of a set of troublesome customers, rather than to cure their ailments.

A physician and surgeon have been appointed to stand inside the doors of the waiting room. They are to receive and examine the patients as they enter and distribute them amongst the various departments, according to their judgement. They are also authorised “to refuse treat-ment to any person who appears not to be a fit object of charity.”

The Lancet investigation into the adminis-tration of the out-patient department of the London hospitals”. There are three articles in all, which make for a fascinating read. If the language used were updated slightly, they could easily have been written 150 years later.

Acknowledgements

I am grateful to Dr Sue Barnes for drawing these articles to my attention.

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BOOK REVIEWS

The 5 minute toxicology consult for PDA


Why am I writing a review of an e-book?

PDAs are small but immensely capable mobile computers with greater processing power than the desktop machines of five years ago. These handheld computers have matured from simple address books to devices that can word process, email, run presentations, manage databases, and (this is the best bit) switch on every television in my house.

Their basic memory varies from 8-64 megabytes but this may be expanded into the gigabyte range. This immense memory together with the ultra portability of the PDAs means that they can always be in your pocket offering near infinite text storage. A PDA may be the perfect way to carry your textbooks with you.

This toxicology program is supplied on a CD-ROM together with nine other programs all from Lippincott Williams and Wilkins. The CD is compatible with Windows CE/PocketPC and PalmOS operating systems; this review used a Compaq iPAQ running PocketPC. The purchased program is the only one with unlimited access but all the others may be used up to 15 times on a trial basis. As the program is supplied on a CD it must be
downloaded via the computer used to syn-
chronise with the PDA rather than directly to
the device. Once the CD is inserted however
the program is straightforward. The entire
program is then transferred onto the PDA
when it is next connected.

The program must be activated for it to
permit unlimited use. This process requires
both internet access and some intuition. The
15 item alphanumeric code supplied with the
disc must be entered into the Lippincott
Williams and Wilkins’ web site together with
the unique code of the PDA. This generates
another code on the web site that then may
be used to unlock the program.

Once up and running, its appearance is
straightforward. Two narrow icon bars, one
at the top of the page and another down the
side, leave plenty of space for the text. The
text size is alterable from “quite hard to read”
to “enormous” and may be made to fit the
screen. Using the basic functions fortunately
did not require access to the scanty “help files”.

Access to the files is either via the main
index (including the ICDC-9-CM index) or the
table of contents (TOC). Using the TOC
option is simpler although this has no search
option. Topics are divided into “General
approach”, “Patient presentations with
toxicological causes”, “Antidotes”, and
“Chemical and Biological agents”.

This is a 4 megabyte text only program.
There are lots of entries. Each entry has a
similar format, being divided up into “Smart
tabs” of Basics, Diagnosis, Treatment, Follow
up Indications, Contraindication and Adverse
Effects, Dosage and Method of Adminis-
tration, Pitfalls, and Miscellaneous. Sensibly
not all “smart tabs” are available for each entry.
Some differences are seen between this
North American e-book and UK practice. These
include the recommendation for induced emesis
for decontamination or the use of oral N-acetylcysteine
in paracetamol poisoning. The vast majority of the
text, however, reflects transatlantic agreement.

A facility for written and even spoken
notes exists and the entries are cross indexed.
If any other LWW programs are on the PDA,
these are also cross indexed. There is a
“back” button to improve navigation but the lack
of a “forwards” option meant I had to
temporarily retrace my steps after using it. The “history” function at least
made this process easier.

Unlike written textbooks, free updates are
available for one year via the Lippincott
Williams and Wilkins’ web site after program
purchase.

Overall this e-book is easy to use and has
a vast amount of comparatively current data on
toxicology. Anyone who needs access to
poisons information but cannot access
Toxbase would benefit from this program.
As external departments in the UK have
internet access there may be little scope for
its use in A&E. However, it may well have
a place in the general practitioner’s bag, pre-
hospital care, or in remote environments.

Disaster medicine

D E Horgan, J L Burstein, editors. Lippincott
Williams and Wilkins, Philadelphia, 2002,

The world is a dangerous place to live in’, says
David Hogan and Jonathan Burstein. Today,
it seems that this statement was never as true
as the solitude of one’s office seems worlds
apart from the frenetic troubled Middle East
yet never has there been a time when preparedness
was so important.

I turned to this book as a timely opportu-
nity to learn from other’s experiences and
expertise and to cross check my own depart-
ment’s state of preparedness with the
unexpected. It contains many reports of
previous disasters; maritime, terrorist, avia-
tion, radiation and mass gathering disasters
for example. However, it is the section on
conflict related disasters that seems most
appropriate at present. Time has already,
perhaps, overtaken the authors and the
concern about bioterrorism in particular has
developed highly pertinent. Transient as they
might be, references to the helpful CDC and
WHO web sites in this regard would have
been a helpful addition as would reference to
a number of other pertinent web sites.

The sections are far from comprehensive
but sufficiently stimulating to make the
reader search elsewhere for further informa-
tion. The authors of the various chapters
are exclusively American but have successfully
resisted the temptation to make this parochial
in their choice of disasters to illustrate their
chapters. Nevertheless the recommended
response has a distinctive North American
influence centred around an efficient EMS
but at the expense of a prehospital care
system that differs in many ways from the
UK and European models.

The chapter authors have evidently been
given considerable licence in writing their
chapters. This makes for challenging reading.
A more uniform approach might facilitate the
reader’s quest for information.

The editors propose a clinical approach
although the depth of the clinical approach
could be greater. For instance drug doses and
therapeutics in general are understated. This
is apparent for example in the chapter on
mass gatherings where a list of the doses
and volumes of medications required might
be helpful to the reader planning a service for a
major gathering.

It seems to me that this is a book more
suitable to the practical emergency health care
‘planner’ rather than the ‘provider’ as
suggested by the editors. For those of us
actively engaged in reviewing preparedness
for disasters it is a worthwhile text that stimu-
lated me to consider many aspects of my own
department’s plans. However this is not a text
for the provider to turn to on disaster day.

J M Ryan

ACLS for EMT-Basics

M Smith, Jones and Bartlett Publishers,

In the UK, most ambulances are staffed with
one technician and one paramedic—a skill
mix that results in particular challenges
when managing cardiac arrests. British emer-
gency medical technicians (EMTs) are routi-
lessly taught to perform resuscitative activity
and a chapter of their Basic Training Manual
is devoted to this topic. The review book
therefore has the potential to provide addi-
tional in depth information for UK EMTs and
others working alongside Advanced Life
Support colleagues.

The book encompasses airway manage-
ment, emergency cardiac care, abnormal ECG
recognition, defibrillation and pacing, pharma-
cology of cardiac emergency drugs, special re-
suscitation situations, legal issues, and stress.
It is attractive and includes plentiful pictures
and sidebars, and a comprehensive index. More-
over, it minimises the risk of appearing daun-
ting to its proposed audience of EMTs in basic
or continuing training, as it is no thicker than
the average Sunday newspaper supplement.

The author has clearly struggled with
considerations about what material to incor-
porate, but unfortunately has not resolved
this issue consistently. For example, the
airway chapter describes basic manoeuvres
and adjuncts in great detail but does not
mention the recovery position. Endotracheal
intubation is described at length, but inter-
mediate adjuncts such as the Combitube are
omitted. Perhaps the most obvious omission
for devices for confirming endotracheal tube
placement are used; positioning of defibrilla-
tion pads/paddles and energy level selection
are not described; the pathophysiology of
airway trauma is described but not the lung
sidebars, and a comprehensive index. More-

The language used is an odd mixture of
patronising simplicity (“Lidocaine is used to
lessen the pain of an irritable, hurting heart”) and
potentially impenetrable medical jargon (the terms “half-life” and “fibrillation threshold” are mentioned but not explained).

Confusingly, the text alternates between the
perspective of an EMT observing a paramedic
and that of a paramedic undertaking a procedure. This risks leaving readers with
the inappropriate impression that, for example,
EMT’s responsibility to correct intubation of the oesophagus.

The book contains important errors. It
implies that the carabos are level with the
angle of the jaw; that crystalloids remain
within the vascular compartment; that selec-
tion of the correct diameter of nasopharyn-
geal airway should be based on the patient’s
sex; and that “an unrecognised oesophageal
porch” is still used (The [defibrillation] current). An
ECG poricing to show a prolonged p-r interval is printed in reverse, rendering it
useless.

Sentence construction often renders the
text difficult to read and introduces the
potential for some entertaining misunder-
standings. For example, “Automated implan-
table cardiac defibrillators usually are placed
into patients with a history of a near-death
experience” and “The [defibrillation] current
is delivered through the pads or paddles of
the machine while on the patient’s chest”.

Some ambulance technicians may feel that
this book should be subtitled “EMTs are
capable of much more than carrying the
paramedic’s kit”. As such, it has the potential
to fulfil an important unmet need. Sadly, it
does to fail so through poor attention to detail
and a lack of consistency in the level of
clinical information it seeks to deliver to its
target audience.

M Woollard

Reference

1 Institute of Health Care and Development.
Ambulance service basic training manual. Bristol:
IHCD, 1999.