Correspondence to: Dr P Gilling, Accident and Emergency Department, The Leeds General Infirmary, Leeds, Yorkshire, UK; hegartydeirdre@ireland.com
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Comprehensive drug screening
We read with interest the paper by Fabbri et al on comprehensive drug screening. We are concerned by the statement that the “Diagnosis was made on the basis of plasma or urine concentrations of drugs or their metabolites in amounts sufficient to explain the presenting symptoms.” The presence of drug in a screen should imply neither intoxication nor clinical effect, as drug or metabolite may persist for days after toxicity wanes. This is particularly important because many drugs have unique pharmacokinetics, may induce tolerance, or simply do not follow the traditional dose response curve, making the interpretation of a qualitative drug level unreliable. Additionally, it is unclear from the text how the diagnosis and disposition were defined or proved, as no outcome data were presented. It is unclear that outcomes would be changed by the test results, given the poor intraobserver agreement reported.

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. In addition, it is our belief that acetonaphen is the only drug screen that has been shown to have a clinical impact in intentionally self poisoned patients. 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 acetonaphen 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.

H A Grelle, F Barrueto Jr
New York City Poison Control Center, 455 First Avenue, Room 123, New York, NY 10016, USA
Correspondence to: Dr H A Grelle, greller@verizon.net

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 UK1 and Australasian2 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 in the study which 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 mention that the 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)”.

M C Howes
Accident and Emergency Department, Royal Preston Hospital, Preston PR2 9HT, UK; martenhowes@doctors.org.uk

References

Authors’ reply
Howes’ 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. 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 ability, the 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/concentration variation with the Quantumflex RA machine originally manufactured by Cyprane, Keighley, England and now by Matrix Medical, New York.

We agree with Ellows 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 produced by inhalation of nitrous oxide in oxygen.

We fully accept that the methods used were not rigorous enough to accurately quantify numbers of bacteria for any given measured area. However, our work was simply described as a preliminary investigation and this pilot study did identify shortcomings 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 shortfalls 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;

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 that 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.

J Louis
Emergency Department, Taunton and Somerset Hospital, UK

S J Bridges
Paediatric Department, Taunton and Somerset Hospital

Correspondence to: Dr J L Louis, Emergency Department, Taunton and Somerset Hospital, Taunton TA1 5DA, UK; jason.louis@tst.nhs.uk

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 editor of the report that 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 “unacceptable levels of bacteria.”

The authors make no attempt to quantify levels of bacteria for any given measured area. We fully accept that the methods used were not rigorous enough to accurately quantify numbers of bacteria for any given measured area. However, our work was simply described as a preliminary investigation and this pilot study did identify shortcomings 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.

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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.

Y Ngam, J Cutter
School of Health Science, University of Wales, Swansea SA2 8PP, UK; y.ngam@swansea.ac.uk

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-teen girls, has received thanks from their mothers: the mothers emphatically prefer the magnets to pierced 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.

L Finegold
Department of Physics, Drexel University, 3141 Chestnut Street, Philadelphia, PA 19104, USA; lbfinegold@usa.net

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 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.

B W Martin
Emergency Department, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL, UK; bruce.martin@virgin.net

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 SimplRed (DD) assay as the 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 curve of the doctors assessing the SimplRed test? The robustness of the data and the need for improved interobserver reliability was measured, for example by κ and weighted κ statistics. Secondly, cut off points are critical in diagnostic testing because they determine the assay sensitivity and 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?

A Wakai
Department of Emergency Medicine, Beaumont Hospital, Dublin V, Republic of Ireland; wakai@indigo.ie

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 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 squish playing.

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

References


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 treatment to any person who appears not to be a fit object of charity."

Naturally desirous of gaining all the experience possible, the house-surgeons have been in the habit of keeping all the interesting cases under their own care, and of sending the chronic and incurable to the out-patient room…

There are three articles in all," which make for a fascinating read. If the language 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.

E Walker
Emergency Department, Dewsbury Hospital, Halifax Road, Dewsbury, West Yorkshire WF13 4HS, UK; dr.ed@ntlworld.com
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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 synchronise 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 ICD-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 Administration, 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, those in the disc are cross indexed. There is a “back” button to improve navigation but the lack of a “forwards” option meant I had to sometimes laboriously 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 paramedics in departments in the UK most 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.

5 Bush

Disaster medicine


‘The world is a dangerous place to live in’, say 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 opportunity to learn from other’s experiences and expertise to cross check my own department’s approach with that of others working alongside. The vast majority of the text, not all “Smart tabs” are available for each chapter. This makes for challenging reading. A more uniform approach might facilitate the reader search elsewhere for further information.

The authors of the various chapters are exclusively American but have successfully resisted the temptation to become 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 same time 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 search elsewhere for further information.

The editors propose a clinical approach although the depth of the clinical approach could be greater. For instance drug doses and therapeutic options 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 a reader planning a service for a major gathering.

It seems to me that this is a book more suitable to the practicalising emergency health care ‘planner’ rather than the ‘provider’ as suggested by the editors. For those of us who are actively engaged in reviewing preparedness for disasters it is worthwhile text that stimulated 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


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 emergency medical technicians (EMTs) are routinely taught to develop specific activities and a chapter of their Basic Training Manual is devoted to this topic.’ The review book therefore has the potential to provide additional in-depth information for UK EMTs and others working alongside Advanced Life Support colleagues.

The book encompasses airway management, emergency cardiac care, abnormal ECG recognition, defibrillation and pacing, pharmacology of cardiac emergency drugs, special resuscitation situations, legal issues, and stress.

It is attractive and includes plenty of useful tables and key points along the sidebars, and a comprehensive index. Moreover, it minimises the risk of appealing daunting 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 incorporate, 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 intermediate adjuncts such as the Combitube are not mentioned. The text is unlikely to facilitate the recognition of abnormal ECGs.

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, an EMT’s responsibility to correct intubation of the oesophagus.

The book contains important errors. It implies that the carboles are level with the angle of the jaw; that crystalloids remain within the vascular compartment; that selection of the correct diameter of nasopharyngeal airway should be based on the patient’s sex; and that “an unrecognised oesophageal tube still works to isolate the lungs”. An EMTs 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, an EMT’s responsibility to correct intubation of the oesophagus.

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