What to do about psychological distress in emergency department senior house officers?

The article by McPherson et al generates some interesting questions concerning disproportionately high levels of psychological distress among emergency department senior house officers (SHOs). The combination of shift work, a challenging working environment, a demanding caseload, and a lack of support from senior colleagues may explain the findings.

Providing training and support for SHOs could help to reduce distress levels. The editors will decide as to whether to incorporate a session on stress management into our SHO teaching, perhaps in conjunction with administration of the GHQ and brief COPE questionnaires. Providing this training and support for SHOs could help to reduce distress levels.

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Contact lenses can compromise the corneal epithelium and act as pathogenic vectors, facilitating the development of bacterial keratitis. Most corneal abrasions heal quickly when treated with topical antibiotics, which act as lubricants and antimicrobial agents. However, in contact lens wearers there may be rapid progression to corneal scarring or even perforation.

Two patients with contact lens related corneal abrasions, who were initially treated with topical fusidic acid or chloramphenicol, have presented with corneal stromal abscesses. The abscesses developed 12 hours and three days respectively after diagnosis of simple corneal abrasion. Visual acuity was perception of light and hand movements. Both required admission for intensive topical fortified gentamicin and gatifloxacin.

Pseudomonas aeruginosa and Proteus were grown, which were resistant to chloramphenicol and fusidic acid. Best corrected visual acuities were 2/60 and 6/36, respectively. Resolution of the infections; one patient has proceeded to corneal grafting.

A 15 year study of resistance in bacterial isolates from corneal scrapings found that 30.4% of isolates were resistant to chloramphenicol (54% of Gram negative organisms), with a significant increase in resistance during this period. Once microbial keratitis is established, a combination of topical fortified aminoglycoside and cephalosporin or fluorquinolone is indicated; no trend for increasing resistance to these antibiotics was observed in the aforementioned study.

Contact lenses are the most important risk factor for the development of bacterial keratitis. In the emergency department, a history of contact lens wear should be sought, with urgent review of worsening abrasions. We advise that all contact lens related red eyes should be referred to the ophthalmology department, as clinical signs may initially be subtle and corneal scraping may be warranted. Timely commencement of gatifloxacin with the first sign of infection, may greatly reduce the chance of poor outcome.

Contributors
Shane Quinn treated the second patient, reviewed the literature and wrote the paper. Jeffrey Kwartz treated both patients and contributed to the discussion of core ideas. He was the supervisor and is the guarantor.

S M Quinn, J Kwartz
Department of Ophthalmology, Royal Bolton Hospital, Bolton, UK
Correspondence to: Ms S Quinn, Department of Ophthalmology, Royal Bolton Hospital, Farnworth, Bolton BL4 0JR, UK; shanaquin@gmail.com
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References
The limitations of the medium are inherent to all books that profess to teach radiology: particularly in an A5 format large radiographs are reduced to small pictures in which the detail is lost. This may be one of the reasons why the section on head computed tomography is poorly highlighted in boxes and the use of diagrams is poor. I know it is considerable! to produce an accessible, comprehensive textbook of radiology (for example, the young); the temporary stabilization trajectory, in which the patient is resuscitated despite the fact that the short term prognosis is poor; and the stabilization trajectory, in which prompt resuscitation leads to a better outcome.

The book is written from a sociologist’s perspective, and therefore does not aim to provide answers—just observations. Yet despite the North American setting, it raises questions that are highly applicable to UK practice, and this book should be required reading for all ALS providers.

**Handbook of paediatric emergency medicine**


Knowledge is a process of piling up facts; wisdom lies in their simplification. Martin Luther King, Jr (1929–1968)

Upwards of two million children will attend accident and emergency departments in the United Kingdom every year. Many thousands more will attend general practice for advice or treatment after acute illness or injury. Large numbers of practitioners in many different settings therefore need to be prepared to deal with children with a variety of urgent and emergency conditions. As an old Chinese proverb states “Small children do not pretend to be sick”. The problem is that the vast majority of children have minor to moderate illness, much of which is self limiting. Indeed many of the injured children require little more than symptomatic relief and general supportive care.

The problem therefore is identifying the wheat from the chaff. In other words, how does one identify the critically ill child, or the child who is brewing something serious? Age and experience help. Certainly knowledge is useful. More often the wisdom of Solomon is required. There is no doubt that experience brings greater wisdom, and with it ability to deal with children effectively. I suppose that is really what I like about this book. The authors have brought their collective experience and wisdom, gathered over the years (I am not brave enough to state how many, but I know it is considerable!) to produce an extremely readable text that is well laid out and well presented. The salient features are highlighted in boxes and the use of diagrams is good. Personally I would have liked to see more radiographs and clinical pictures, but then again this may not be the purpose of a handbook. This may best be left to a colour atlas, or better still, a practical guide. Computed tomograms of the head are poorly produced and this is again disappointing.

This book covers virtually all the salient features of paediatric emergency medicine. There are no glaring omissions, although one always has pet subjects one would wish to see incorporated. It would be churlish to let these personal idiosyncrasies detract from the overall good feel I have for this text. There is no doubt that this book will provide useful reading at all levels of experience. Reading it and being familiar with the contents will bring greater knowledge. Wisdom, I’m afraid will have to come with time. The only major problem with this book is that it is a bulky, heavy hardback. As such it won’t fit into a pocket conveniently and may well end up on the shelf. By being left on the shelf it runs the risk of being ignored and this, I think, would be a tragedy.

Martin Luther King would be proud of this effort.

**Core cases in critical care**


In 230 pages and a few monochrome illustrations this paperback covers the top 20 clinical problems in a stock index set of every intensive care unit. The authorship is a reassuring collection of UK intensivists, a who’s who? of the Intensive Care Society. I liked the standardised format; case histories are followed by discussion of the clinical features with reference to pathophysiology, treatment options, and outcome. A panel of key learning points rounds off each chapter, and the recommended further reading is appropriate and proportionate.

A number of the cases bear upon emergency care and many are set in the resuscitation room. The importance of securing the ABCs is emphasised before discussion of theoretical concepts, not always the case in books of this sort. This reflects the interests of the authors, many of whom are active in education at the interface between intensive care and emergency medicine. Relevant cases include burns, trauma, and overdose, but pyrexia is included uncomfortably in the chapter on status epilepticus. The chapters are up to date; the roles of inhaled nitric oxide and prostacyclin are reviewed, and there is a review of the evidence on non-invasive ventilation in COPD. Activated protein C is (to this reviewer at least) a very new treatment in septic shock, and its brief role is included in the chapter on sepsis.

This reviewer has an aversion to diagrammatic representation of pulmonary physiology, lung capacities, closing volumes, and zones of perfusion. The authors avoid such esoteric concepts, and there is no assumption of knowledge of molecular biology in the chapter on sepsis and multiple organ failure. Cardiac care is in the major omission from what is otherwise a reasonably broad based content.

Trainees in intensive care medicine from all parent specialties will find this a useful and accessible resource. It sets out to present a consensus approach to common clinical problems, and is not a comprehensive textbook. For any specialist registrar about to start a secondment in the ICU this little book would be a good investment.

J E France

Sudden death and the myth of CPR


Most emergency physicians will sometimes recognise a feeling of futility during cardio-pulmonary resuscitation (CPR)—the algorithm is followed despite the fact that most of those present know the attempt is doomed to failure, or frankly inappropriate.

Stefan Timmermans is a Belgian healthcare sociologist who spent time in American emergency departments observing the rituals surrounding CPR. His book questions the notion of CPR for all, and the over-optimistic prognosis of survival from out of hospital cardiac arrest that is portrayed in the media, and by some medical authorities. The book describes the attitudes and feelings of doctors, nurses, and paramedics, their definitions of good and bad resuscitation attempts, and the way in which they feel constrained by guidelines and lawyers.

The chapters are wide ranging and include the evolution of resuscitations techniques, death awareness, and what constitutes a “good” death, as well as discussion on advance directives and the presence of relatives during resuscitation attempts. The author divides resuscitation attempts into four distinct cases: the catastrophe; the temporary stabilization trajectory, where the victim is presumed to have high social viability and receives aggressive resuscitation irrespective of clinical viability (for example, the young); the temporary stabilization trajectory, in which the patient is resuscitated despite the fact that the short term prognosis is poor; and the stabilization trajectory, in which prompt resuscitation leads to a better outcome.

The book is written from a sociologist’s perspective, and therefore does not aim to provide answers—just observations. Yet despite the North American setting, it raises questions that are highly applicable to UK practice, and this book should be required reading for all ALS providers.

J R Benger

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