LETTERS

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, broad case mix, and newly acquired decision-making responsibilities can contribute to high levels of psychological distress. It is interesting to note that once we find the time to incorporate a more formal session on stress management into our SHO teaching, perhaps in conjunction with administration of the GHQ and brief COPE… once we find the time to do this, we will see a positive impact.

Unfortunately, there is no easy answer to the question of how to deal with the high levels of psychological distress among SHOs. One potential solution could be the implementation of a formal mentoring scheme, which could provide a support system for SHOs to help them navigate the challenges of their role. Another option could be the provision of regular contact with a consultant supervisor, who could help SHOs to recognize the need for support and provide guidance on how to seek it out.

However, it is important to note that simply providing resources and support is not enough. SHOs need to be encouraged to recognize their own psychological distress and seek help when they need it, rather than bottling it up and hoping that it will go away. This requires a shift in the culture of the emergency department, where it is acceptable and even expected for SHOs to seek support when they need it.

Furthermore, it is important to recognize that psychological distress among SHOs is not just a problem for the individual SHO, but for the department as a whole. SHOs are more likely to perform better when they are supported and have the resources they need to do their job. This means that the department as a whole needs to take responsibility for addressing the issue of psychological distress among SHOs, rather than leaving it up to individual SHOs to handle on their own.

In conclusion, while there is no easy answer to the question of how to deal with psychological distress among SHOs, it is clear that this is a serious issue that needs to be addressed. By providing resources and support, encouraging SHOs to seek help when they need it, and taking responsibility as a department, we can work towards creating a more supportive and inclusive environment for SHOs.

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References

The hidden dangers of dietary supplements

With increasing health awareness, many parents give children dietary supplements. Getting children to take tablets is difficult therefore manufacturers have produced supplements in “novelty” shapes, for example cartoon characters. We did have some reservations about the article by McPherson et al, which highlighted the dangers of children taking dietary supplements.

In our emergency department there have been two cases to date of children presenting with accidental overdoses of vitamin and iron supplements. The toddlers, aged 2 and 3, had taken 20 and 15 tablets respectively. The children had thought that the supplements were sweets and indulged themselves. Both were admitted and blood serum iron concentrations taken. Fortunately, neither child needed further treatment, both making an uneventful recovery.

Severity of iron ingestion depends on the total elemental iron taken. Preparations are available incorporating iron in a number of different compounds. Ferrous sulphate contains 20% elemental iron, ferrous fumarate 33%, and ferrous gluconate 12%. To calculate the total elemental iron ingested, the compound involved and the number of tablets taken must be known.

Elemental iron ingestion above 20 mg/kg is likely to produce features of toxicity, above 60 mg/kg possible fatality. Preparations for children are available with elemental iron content of 6 and 12 mg. For a typical 3 year old therefore, ingestion of less than 25 tablets may result in toxicity requiring treatment; 70 tablets potential fatality.

From 12 March 1998 to 31 December 2001, there were 90 product accesses to combined iron and multivitamin tablets on Toxbase, 12 of which were from Northern Ireland (Scottish Poisons Information Bureau, The Royal Infirmary, Edinburgh, personal correspondence April, 2002; NHS National Poisons Information Service, Edinburgh Centre, Personal correspondence Feb, 2002).

Products of this type are licensed as food supplements, not as a medicine, as they do not purport any medicinal claim. The quality of the product is governed by the Food Standards Agency. Children are legally permitted to purchase the product. Carefully worded packaging and increased consumer awareness is necessary to prevent a fatality.

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Glucagon use in symptomatic β blocker overdose

I was interested to read the best BET “Glucagon for the treatment of symptomatic β blocker overdose” by Boyd and Ghosh.1 As the authors recognised, the six studies tabulated were of mixed overdose or had other risk factors for cerebral edema in children with diabetic ketoacidosis. N Engl J Med 2001;344:264-9.

The evidence for glucagon in treating symptomatic β blocker overdose will probably never reach a higher level than case reports. This is true of most “antidotes” because of ethical constraints on toxicology studies. Glucagon, however, has been shown to be effective in treating symptomatic β blocker overdose in various controlled animal studies.

About 20 deaths per year in the UK are attributed to β blocker overdose. The authors state that glucagon is expensive. It is true that large doses may be required and that this may outstrip hospital supplies. However, at an initial dose of 5–10 mg (100 μg/kg) intravenously at £19.95/mg, the cost compares favourably with thrombolysis as a potential lifesaving intervention. Atropine has been shown to be spectacularly ineffective in this setting and alternatives such as β agonists, phospho-diesterase inhibitors, insulin-euglycaemia, and pacing have significantly more associated complications than glucagon without improving outcome.

Glucagon treatment for symptomatic β blocker overdose should not yet be discarded on grounds of cost or lack of evidence.

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References


Emergency management of contact lens associated corneal abrasions

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. Once microbial keratitis established, a combination of topical fortified amoxicillin and cefazolin or fluoroquinolone is indicated; no trend for increasing resistance to these antibiotics was observed in the aforementioned study.1 Contact lenses are the most important risk factor for the development of bacterial keratitis.2 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. Timing commencement of gatifloxacin with the first sign of infection, may greatly reduce the chance of poor outcome.

Contributors

Shauna 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.

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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 so effective: the pictures are about the same size as the original films. For me, however, there is no substitute for handling and examining the real thing. Until digital radiology finally arrives in the south west of England, that is.

J R Benger

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 programmes 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 resuscitation 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 categories, or “trajectories,” which should be familiar to all practising emergency physicians: the legal death trajectory, where resuscitation is performed mainly as a legal matter; the elite death 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 stabilisation trajectory, in which the patient is resuscitated despite the fact that the short term prognosis is poor; and the stabilisation 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 E France

Handbook of paediatric emergency medicine

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 have seen 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 in practical practice. 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, Jr (1929–1968)

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

T Beatle

Core cases in critical care

In 230 pages and a few monochrome illustrations this paperback covers the top 20 clinical problems in a structured 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, relevant tables, and a recommended further reading list. The chapters are up to date; the roles of inhaled nitric oxide and prostacyclin highlighted in the appropriate chapter. 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 mention is testimony to the book’s contemporarorquality. The Swan Ganz catheter is placed in its correct context, alongside alternatives including the pulse induced continuous cardiac output monitor. I was also pleased to see the role of corticosteroids set out in accordance with current thinking on the treatment of 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 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.

P Nee