LETTERS TO THE EDITOR

Blood alcohol levels

Sir

As senior house officers in a busy accident and emergency department, we were often required to deal with alcohol-related problems. We felt that a knowledge of blood alcohol levels in certain cases would be of benefit, for example, the unconscious or stuporose patient.

The Lion Alcolmeter seemed to be an ideal instrument to gain such measurements, being painless, immediate and easy to operate. Therefore, we set out to test the reliability of the Meter in the clinical situation.

Our tests revealed a number of limitations in the accuracy and usefulness of the Meter and the main shortcomings are outlined below. Firstly, accurate estimates of blood alcohol levels were only obtained from those patients coordinated and cooperative enough to give a mouth sample, i.e. low risk patients. Estimates from unconscious or uncooperative patients (obviously high risk) had to be made from nasal samples and were inconsistent and unreliable. Secondly, readings cannot be taken less than 20 min following ingestion or vomiting of alcohol. Timing such events is obviously difficult to assess in the unconscious patient.

We also found, as expected, that the relationship between blood alcohol level and conscious level was extremely variable, the individuals alcohol tolerance being the most important factor. Thus, knowledge of blood levels is of little consequence in unknown individuals. We found that in no patient tested by the Alcolmeter did alcohol levels alter the treatment, the clinical state being of far greater significance.

Thus, the reliability of the Lion Alcometer as an indicator of blood alcohol levels in the unconscious patient in the clinical situation must be questioned and the value of such knowledge also seems limited.

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Toe nails

Sir

I wonder if your comments on toe nails at the end of the Editorial (Archives of Emergency Medicine, Volume 3, Number 4, December 1986), while most placatory in tone, were meant to provoke some thought and debate.

To my mind, and for want of a better term, ingrowing toe nails are a nuisance. They
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are a nuisance to the patient who has to bear a certain amount of inconvenience, and frequent visits to a chiropodist or to his general practitioner.

They are a nuisance to the patients' general practitioner who feels he is being pestered for such a lowly condition (and doesn't know what to do about it) and is likely to be pestered in this way for some time till the appointment he makes for the patient to attend a general surgical or orthopaedic outpatients comes to fruition.

They are a nuisance to the general or orthopaedic surgeon who feels there are more momentous things to do and relegates the ingrowing toe nail to be done by the senior house officer at the end of his waiting list for patients to be called in for minor operations.

In spite of all the above, and certainly not because of the above, ingrowing toe nails are NOT accidents and/or emergencies.

Accident and emergency departments face a lot of problems. One of the main problems is having to deal with patients attending inappropriately on their own or having been referred to accident and emergency departments inappropriately by their general practitioners.

The introduction or encouragement of treatment for ingrowing toe nails as an accident and emergency responsibility is only the thin edge of a very big wedge. There are a lot of other conditions (a nuisance to patients and general practitioners alike) which would come to be considered germane to the speciality of accident and emergency medicine and surgery if we give patients or their general practitioners half the chance.

The specialities who now, and rightfully, have to deal with verrucas, warts, corns, dermatoses, tennis/golfer's elbow, frozen shoulders, varicose veins, ear wax, perennial rhinitis, menstrual irregularities and habitual overdosers (to name a few) would be too glad if accident and emergency departments volunteered their services to usurp the treatment of such cases.

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The seat-belt sign

Sir

The letter published in the last edition of Archives of Emergency Medicine (Volume 3, Number 4, December 1986) by Rainey & Ritchie described an unusual clinical sign following negative peritoneal lavage which prompted early diagnosis of a retroperitoneal duodenal ulcer.

This case clearly reinforces the growing pile of evidence in support of the 'Seat-belt sign' as an important indicator of the likelihood of intra-abdominal injury following seat-belt trauma to the abdomen.

The seat-belt syndrome was first described by Garrett & Braunstein in 1962 but