LETTERS TO THE EDITOR

Inter-scalene brachial plexus blocks

Sir

The authors of this study have presented a very useful technique which can, with suitable precautions, be used in the accident and emergency department. I note that, although virtually 50% of their patients developed complications, these were minor. I note that they emphasize that a short needle must be used to minimize the risk of major complications. As a person who has used this technique in the past, may I further emphasize this point. When using this technique in the past, with a longer needle, a patient of mine has undergone a total spinal anaesthetic inadvertently. This was presumably due to leakage of the local anaesthetic (1% lignocaine with adrenalin) into a dural sheath. In this case the volume of anaesthetic was of the order of 5 mls before symptoms began and the procedure was terminated. Following intubation and circulatory support, the outcome was uneventful and the operative procedure was carried out as planned.

In addition to advising cautious use of a short needle, it is my firmly held view that no regional blockade technique should be used unless the patient is in an area where full resuscitation facilities exist i.e., ability to intubate, ventilate, support the circulation and reverse arrhythmia. I now utilize 1% plain prilocaine for all regional blockade procedures and will only carry them out in a suitably equipped area after formal consent has been obtained from the patient.

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Accidents in the accident and emergency department

Sir

Accident and emergency departments exist to provide prompt and appropriate care to those ill and injured patients in urgent need. Some patients also suffer accidents during the therapeutic process; hospitals have been shown to be unsafe for patients (Snell, 1956; O'Brien et al., 1987; Banco & Powers, 1988) and for staff (Flournoy & Rickard, 1987).

As part of our departmental quality assurance process, we studied 'accident forms' relating to any incidents involving patients which occurred between 1.1.1987 and 31.12.1988 (n = 32). During this period, 103151 patient attendances took place in the Department, giving an accident rate of 31/100,000 attendances. An age/sex breakdown of attenders and accident victims is shown in Table 1.
The incidents could be divided into two broad groups; (1) Falls (n=16). Fifty percent of falls involved patients over 65 years, and three quarters of these (n=6) were elderly females. Three patients (18-75%) fell as a complication of alcohol or other sedative drug dosage. Two patients (12.5%) fell while using crutches. (2) Miscellaneous Accidents (n=16) which included 'faints', cuts, bruises and abrasions.

Five patients (31.25%) were elderly women. No serious injuries were sustained. The over representation of elderly women was a significant finding ('Chi squared' test) among (a) All accidents (p<0.001) and (b) Falls group (p<0.01), but not among (c) Miscellaneous accidents group (p<0.1). An accident ratio was calculated for each age/sex group by comparison of observed and expected percentages (Table 1). Females over 65 years were over-represented with an accident ratio of 3.840.

Table 1  Percentages of total attendances, accidents, falls, miscellaneous accidents and accidental ratios by age and sex

<table>
<thead>
<tr>
<th>age (years)</th>
<th>sex</th>
<th>% attendances (n=103151)</th>
<th>% accidents (n=32)</th>
<th>% falls (n=16)</th>
<th>% miscellaneous accidents (n=16)</th>
<th>accident ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>M</td>
<td>12.6</td>
<td>9.375</td>
<td>6.25</td>
<td>12.5</td>
<td>0.746</td>
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<td></td>
<td>F</td>
<td>9.1</td>
<td>6.25</td>
<td>6.25</td>
<td>6.25</td>
<td>0.687</td>
</tr>
<tr>
<td>16-65</td>
<td>M</td>
<td>38.7</td>
<td>25.0</td>
<td>18.75</td>
<td>31.25</td>
<td>0.646</td>
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<tr>
<td></td>
<td>F</td>
<td>24.4</td>
<td>18.75</td>
<td>18.75</td>
<td>18.75</td>
<td>0.768</td>
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<tr>
<td>66+</td>
<td>M</td>
<td>6.3</td>
<td>6.25</td>
<td>12.5</td>
<td>0</td>
<td>0.992</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>8.9</td>
<td>34.375</td>
<td>37.5</td>
<td>31.25</td>
<td>3.840</td>
</tr>
<tr>
<td>Chi²</td>
<td></td>
<td>p&lt;0.001</td>
<td>p&lt;0.01</td>
<td>p&lt;0.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The health and safety of our patients must be one of our prime responsibilities. Inpatient accidents have been studied, and have led to the formation of systems of quality assurance (O'Brien et al., 1987). Snell (1956) studied 653 inpatient accidents and found that 89% were falls; he also found that the incidence of accidents rises sharply over the age of 60 years. In our study falls accounted for 50% of accidents, with elderly females being most at risk. Intoxicated patients were another clear risk group.

Assuring the quality of care involves establishing criteria of care, collecting and analyzing appropriate data and acting upon the results (O'Brien et al., 1987). This study serves to identify 'at risk' groups. In future, these patients will be identified at the outset, allowing greater care and closer monitoring to be provided. Subsequent annual analysis of accidents; with the calculation of rates and accident ratios, will be used to monitor and evaluate the effectiveness of our efforts. We would recommend a similar process to all who wish to monitor the quality of care within their department.


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Recurrent Herpetic whitlow

Sir

Herpetic whitlow is usually a benign but painful nuisance. It can however cause more serious problems for patients and doctors than is generally realized as outlined below.

A thirty-nine year old D.I.Y. shop manager presented to the Accident and Emergency Department at this hospital with a two year history of recurrent painful blister on the tip of his left middle finger. There had been ten episodes in all. It had been treated on different occasions by both general practitioner and local A&E department with incision, antibiotics and poultices. It always resolved slowly, over a period of 2 to 3 weeks. It impaired some aspects of his work but did not require him to take sick leave.

At presentation he had a blister with surrounding erythema. Incision of the roof produced a clear discharge which grew Herpes Simplex virus type 2, Tzanck smear was negative. Culture also grew a coliform sensitive to Trimethoprim. He was treated with simple analgesia. Acyclovir 200 mg five times per day and trimethoprim 200 mg bd, for 5 days. There was a poor clinical response but the whitlow healed gradually over the next 3 weeks. He was advised about future drug prophylaxis (see below).

Treatment of recurrent herpetic whitlow is not well documented and the only series—eight patients—found Acyclovir 800 mg bd for 5 days at the onset of prodromal symptoms prevented cutaneous manifestations (Gill et al., 1956). Treatment during the acute phase is generally ineffective.

It is important for doctors to be aware of the danger of incorrect diagnosis and management as seen in this case. Misdiagnosis may lead to cross-infection and serious illness in immunocompromized, surgery can cause prolonged healing and pain, secondary infection and encephalitis (Carter, 1979; Louis et al., 1979). Health care workers may best avoid infection by wearing rubber gloves (the virus is found in 2-5% of normal adult saliva and 6-5% of bronchial secretions of hospital patients with tracheostomies) (Schwandt et al., 1987).

It can be a significant problem for doctors as in the case of the surgical resident who had to stop direct patient care for 10 days per month over a 4 year period because of recurrent whitlow (Laskin, 1985).

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