

## Letters to the Editor

### Steps are required to improve pre-hospital care

Deakin and Hicks<sup>1</sup> suggest that efforts are required to improve the pre-hospital care of trauma victims, with which I would agree. I do, however, question some of the statistics.

The number of fatalities as a result of road traffic accidents (RTAs) in England and Wales was 4229 in 1992, and fell below four thousand in 1993. The erroneous figure of 14 500 quoted by the authors was an estimate of the total number of annual trauma deaths published in a 1988 document.<sup>2</sup> This same document included a retrospective analysis of 1000 trauma deaths in 11 districts across England and Wales, where 486 (49%) died at the scene or were pronounced 'dead on arrival' at hospital (the range was 23–74% across the districts). The figure that the authors quote of '60%' (actually 58%) of RTA victims dying at scene comes from a smaller study of 434 trauma deaths,<sup>3</sup> and the difference probably reflects poor local pre-hospital care in the more limited area studied (South West Thames). The effect that improving hospital treatment has on survival is therefore conservatively estimated by the authors at 15%, as it is calculated with data from the nationwide survey using the '60%' mortality rate from the local survey.

The second issue is, 'Who should we be educating?' Hussain and Redmond<sup>4</sup> have found that 39% of pre-hospital trauma deaths are preventable, although many of these occur within minutes of the incident. Further extended ambulance service training is unlikely to help this group. The initial responsibility for the management of trauma victims rests with the bystander, and the need for training the public in basic trauma life support skills, whether in an urban or a rural environment, has been recognized in the United Kingdom and in Australia<sup>2,5</sup> (Australia shares a similar epidemiology of trauma to the United Kingdom, with the majority of trauma fatalities following RTAs). Such training should encompass scene safety and control, early mobilization of appropriate emergency services, casualty assessment and casualty treatment. Recommended target groups for training include all vehicle licencees, and children in secondary school.<sup>5</sup> Similar training in video format is currently available for the emergency services<sup>6</sup> (as it may not be the ambulance service who respond first, the police and fire service also

require basic trauma life support skills), and these principles are now being adapted for the general public in Australia.

### REFERENCES

1. Deakin C.D. & Hicks I.R. (1994) AB or ABC pre-hospital fluid management in major trauma. *Journal of Accident and Emergency Medicine* 11, 154–157.
2. Royal College of Surgeons of England (1988) *Commission on the Provision of Surgical Services*. Report of the Working Party on the Management of Patients with Major Injuries. Royal College of Surgeons of England, London.
3. Daley K.E. & Thomas P.R.E. (1992) Trauma deaths in the South West Thames region. *Injury* 23, 393–396.
4. Hussain L.M. & Redmond A.D. (1994) Are pre-hospital deaths from accidental injury preventable? *British Medical Journal* 308, 1077–80.
5. National Health and Medical Research Council (1991) Discussion paper on the management of severe injuries. Australian Government Publishing Service, Canberra.
6. Hodgetts T.J. (1994) Casualty Handling at a Road Traffic Accident: the Combined Emergency Service Response. Greater Manchester County Fire Service Video Production Unit, Manchester.

T.J. HODGETTS

Senior Registrar in Accident and Emergency Medicine and Honorary Trauma Fellow, Department of Trauma, Liverpool Hospital, Liverpool 2170, New South Wales, Australia

### Pre-hospital ABCs: getting the right message across!

Deakin and Hicks<sup>1</sup> provide a biased and, we would respectfully suggest, inaccurate review of the complexities and usefulness of pre-hospital circulatory support in trauma patients. We would like to make three points.

Firstly, the article contains a number of inaccuracies which may be misleading. Pons *et al.*<sup>2</sup> did not 'fail to show any advantage of pre-hospital fluid administration in multiple trauma'. Instead, and to the contrary, they showed that IV access could be achieved within 90 s and that 'these data support the judicious application of fluid resuscitation in pre-hospital trauma care'. Kaweski *et al.*<sup>3</sup> did not find that 'any advantage of early fluid replacement was outweighed by the resultant on-scene delay from initiating an infusion'. Neither does the paper