

### The authors reply

Dr Brooks raises a very important point concerning the transmission of clinical information about patients who are passing from the care of one doctor (unit, hospital) to another. In this example the patient is passing from A&E to an inpatient unit. There is concern that the doctor in the ward may not realise how ill the patient is because there has been no opportunity to see the condition of the patient in the A&E department. With very sick and unstable patients it is the responsibility of the A&E doctor to telephone the ward doctor at the time of admission and give a full verbal report on the patient's condition and the treatment given.

Changing medical practice means that hospital patients are very frequently cared for by several medical disciplines at the same time, for example, the diabetic patient with peripheral vascular disease or the multiply injured patient. In addition the reduction in junior doctors hours of work often results in patients being seen at night by a doctor who does not work in that unit during the day or who has the next day off.

Doctors usually communicate patient details to each other solely by written clinical notes. This is nearly always inadequate. Verbal communication provides different and usually more detailed information; it allows doctors to convey their general impressions about patients more easily and gives them the opportunity to ask each other questions and discuss each patient's management. We would do well to look to the nurses who realise that it is important at each change of staff—or when patients move to different departments—to have a verbal report on each patient in their charge.

Doctors need to set aside time to have a verbal handover of information about each patient in addition to what they have written.

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### Asthma management

EDITOR,—Regarding the article by Robinson *et al*<sup>1</sup> in the March issue, an audit carried out in our department investigated a simpler approach to improving asthma management. We introduced a stamp on the A&E cards of all asthma attendances (see the figure) to prompt doctors to record peak flow values and refer to departmental guidelines based on those published by the British Thoracic Society.<sup>2</sup>

INITIAL PFR	<input type="text"/>	L	MIN
NORMAL/PREDICTED PFR	<input type="text"/>	L	MIN
% PREDICTED	<input type="text"/>	%	
NOW REFER TO ASTHMA CHART			

Stamp used on the A&E cards of asthma attendances.

The A&E notes of 80 successive asthmatic attendances were reviewed for details of peak flow recording, investigation, management, and follow up before and after the intervention described above.

Improvements were achieved in recording peak flow at presentation (84% v 97.5%), predicted peak-flow (21% v 75%) and in sending

a GP letter (21% v 39%). However, we failed to improve prescription of steroids on discharge (56% v 58.5%).

If "inappropriate discharge" is defined as the discharge of a patient with a presenting peak flow of less than 50% of predicted (the BTS guidelines<sup>2</sup> advise admission in such cases), then our intervention failed to alter this measurement: 43% of such cases were discharged after the audit compared to 38% before. Further analysis of these cases revealed that most had markedly improved with nebuliser administration, the mean post-nebuliser peak flow being 80% of predicted. Whether this justifies discharge is debatable but it clearly does not follow national guidelines.<sup>2</sup>

The improvements in peak flow recording we obtained are strikingly similar to those obtained by Robinson *et al* and indicate that simple alterations to the A&E card are all that is required to optimise recording of this essential variable in asthma management. However, their comparative success in reducing the number of inappropriate discharges suggests that the preprinted form is of greater value in ensuring adherence to clinical guidelines.

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### Management of drug overdoses

EDITOR,—We were interested in the recent paper on the management of drug overdoses by Greaves *et al*.<sup>1</sup> Our experience of these treatment variations are similar. Additionally, we have been getting inconsistent advice from different Poison Information Centres. We therefore carried out a small study to assess the consistency of advice given by the Poison Information Centres.

We used five of the same scenarios used by Greaves. These are as follows:

- A 26 year old male who claims to have taken 100 paracetamol tablets one hour previously. He is a chronic attender who has taken many previous overdoses.
  - A 19 year old male who has taken 30 paracetamol 500 mg tablets two hours previously. He has not vomited.
  - An 18 year old female who took 20 diazepam 2 mg tablets two hours ago, after drinking half a bottle of vodka.
  - A 43 year old female who has taken 20 amitriptyline 25 mg tablets four hours previously. She is tachycardic and sweaty.
  - A 45 year old male who has taken 50 aspirin 300 mg tablets eight hours previously. He has nausea and tinnitus.
- Seven of the Poison Information Centres, which were unaware of the study, were telephoned with these scenarios. Their advice with regard to immediate management was noted (table).

It can be seen that advice given by the Poison Information Centres differs widely between centres. We compared the advice given regarding paracetamol overdose with the established national guidelines.<sup>2</sup> The majority of centres recommended lavage (with or without charcoal) but only a minority recom-

### Drug overdose scenarios

Scenario	Lavage and charcoal		Charcoal	Levels	None
	Lavage	and charcoal			
1	2	3	2	—	—
2	2	2	2	1	—
3	—	—	1	—	6
4	—	2	4	—	1
5	—	—	5	2	—

mended initiating treatment with oral methionine (two in scenario 1, three in scenario 2).

One centre advised starting treatment with N-acetylcysteine for scenario 1, which is not recommended in the national guidelines.

The efficiency of gastric lavage is often questionable, especially four hours after a significant tricyclic antidepressant overdose. This uncertainty is shown by the fact that two of the centres still recommended it in scenario 4.

Greaves showed variation in the management of drug overdoses by medical staff. We feel that this may be partly due to the variation of advice given by the different poison information centres. The problem could be addressed by wide circulation of more established national guidelines in the treatment of overdoses.

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### Toddler's fracture

EDITOR,—We read the paper on "toddler's fracture" by Shrivast *et al*<sup>1</sup> and congratulate them for raising the profile of this topic.

There are several aspects of the paper on which we wish to comment.

When discussing fractures in young children there are two distinct clinical entities to be distinguished. The first is a child with a visible spiral fracture to the tibia or femur on initial presentation. We suggest this should be described as a "fracture in a toddler". This is to be distinguished from the situation where no fracture is visible on initial, standard, good quality x rays (and supported by a negative radiologist's report) but where subsequent films, usually at 10-14 days after presentation, reveal a periosteal reaction alone or combined with a fracture line. The term "toddler's fracture" should be reserved, in our opinion, for this latter situation in which a fracture only becomes detectable retrospectively (figure).

The term "missed fracture" is misleading when applied as described in the paper to fractures not detectable by a radiologist. There could obviously be medicolegal consequences with the use of such terminology for an injury which only becomes detectable radiologically on subsequent films.

The stated incidence of toddler's fracture even as described is surprisingly low. Assuming child attendances at the Blackpool accident and emergency unit are 20-25% of the total figures, 15 500-18 000 children attend annually. There are 28 000 new attendances at Edinburgh's Royal Hospital for Sick