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This case report was presented at the 27th National Congress of Turkish Plastic, Reconstructive and Aesthetic Surgery, Konya, Turkey, 14–17 September, 2005.

Accepted 14 November 2006

Competing interests: None declared.

References

1 **Rai I**, Jesche MG, Barrow RE, *et al*. Electrical injuries: a 30- year review. *J Trauma* 1999;**46**:933–6.
2 **Khan AH**, Siddiqui RJ, Pneumothorax due to electrical burn. *Indian J Chest Dis Allied Sci* 1998;**40**:291–3.
3 **Sandhir RK**, Tiwari IN, Goel A. Management of electrical injuries of the abdomen. *Burns* 1992;**18**:253–5.

Liver rupture following delivery: HELLP needed

The incidence of subscapsular liver haematoma formation with subsequent rupture of Glisson's capsule is relatively rare, occuring in 1 in 250 000 deliveries.[1] It usually occurs in pregnancies complicated by eclampsia or by HELLP syndrome.[2] HELLP is an acronym coined by Weinstein in 1982, with the findings of haemolysis (H), elevated liver enzymes (EL) and low platelet count (LP).[3] Rupture of the subscapsular haematoma is one of the life-threatening complications of HELLP syndrome. The presenting features may include right upper quadrant or epigastric pain, shoulder pain, vomiting, or features of shock. Because of the variable presentation combined with low incidence, the diagnosis and management is often delayed.

A 28-year-old woman presented as an emergency, complaining of severe right upper quadrant/right lower chest pain and fainting 12 h after a full term, normal, vaginal delivery of a healthy baby. The pregnancy was uncomplicated, with no history of diabetes, hypertension or eclampsia. Blood pressure was 100/70 mm Hg with heart rate of 120 beats/min. Physical examination revealed decreased air entry in the right lower lung base. Abdominal examination revealed tenderness in the right hypochondrium. Blood counts revealed haemoglobin count of 7.5 g/dl, platelet 57×10^9/l, bilirubin 37 μmol/l, alanine transaminase 685 μ/l, and alkaline phosphatase 127 μ/l. The clotting profile was disturbed, with an international normalised ratio of 1.6 and low fibrinogen 1.4 g/l (normal 1.5–4). A CT scan of the chest ruled out the possibility of pulmonary embolism. However, a CT scan of the abdomen demonstrated rupture of the liver and the bleeding was contained within the hepatic capsule. The patient was then transferred to the regional liver unit for further management.

All doctors in the emergency department must be aware of this condition and have a high index of suspicion. Prompt recognition and management will reduce the morbidity and mortality associated with this condition.

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doi: 10.1136/emj.2006.044735

Accepted 5 December 2006

Competing interests: None declared.

References

1 **Van Dike RW**. The liver in pregnancy. In: Zakim D, Boyer TD, eds. *Hepatology:a textbook of liver disease*. Philadelphia: WB Saunders, 1990.
2 **Schwartz ML**, Lien JM. Spontaneous liver hematoma in pregnancy not clearly associated with preeclampsia: a case presentation and literature review. *Am J Obstet Gynecol* 1997;**176**:1328–33.
3 **Weinstein L**. Syndrome of hemolysis, elevated liver enzymes, and low platelet count: a severe consequence of hypertension in pregnancy. *Am J Obstet Gynecol* 1982;**142**:159–67.

Need for knowledge of local scanners for patients with morbid obesity

We recently came across a very peculiar situation where we could not perform an urgent MRI scan for a patient owing to weight restrictions on the scanner in our hospital (Weston General Hospital, Uphill, Weston-Super-Mare, UK).

A 44-year-old man weighing 197 kg was admitted to our hospital with features of progressive bilateral loss of vision, followed by flaccid paraparesis and loss of sphincter tone, with urinary and faecal incontinence. The patient required an urgent MRI scan of the brain, spinal cord and orbits, but this was not possible owing to weight restrictions on the scanner (<21 stones). The patient was then sent to another hospital for an MRI scan, but the scanner broke under the patient's weight. Finally, the patient was scanned in a private MRI scanner that could take patients up to 250 kg in weight and was diagnosed as having neuromyelitis optica; this whole process took us 7 days. He was transferred to a tertiary hospital and died a few days later.

We have now obtained information regarding the contact of nearby scanners that can take patients with weights up to 250 kg; this has been included in the hospital protocol book.

Obesity is becoming an increasing problem within the UK.[1] Hospitals can expect more patients with weight in excess of the upper limit for most scanners. Given our experience, we think that hospitals should set up contact with nearby scanners that can scan patients with obesity locally, thereby saving lives and preventing potential medicolegal problems.

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Accepted 2 February 2007

Competing interests: None declared.

Reference

1 **Haslam DW**, James WP. Obesity. *Lancet* 2005;**366**:1197–209.

Reviewing blood test results: a worthwhile chore or a waste of time?

It has previously been the practice of many emergency departments (ED) in the UK to routinely review the blood test results of all discharged patients. This time-consuming job is usually performed by a middle grade doctor to act as a safety net in case significantly abnormal blood tests were not acted upon at the time of presentation. We looked at all the blood test results of discharged patients over an 18-month period in a UK ED to see whether discontinuing this practice could be justified. Of the 940 tests evaluated, 128 (13.6%) were abnormal and of these 9 (0.96%) were deemed significantly abnormal—that is, outside the normal range—with the potential to have a clinical effect, and did not have appropriate action documented in the notes by the ED doctor. These nine results were followed up by means of a telephone conversation with the patient's general practitioner. No harm to any patient was demonstrated as a result of the ED attendance. Three patients required further blood tests, all of which confirmed that the initial abnormal result had normalised without treatment. One patient required an outpatient ultrasound scan that confirmed the ED diagnosis of gall stones. Given our results, we concluded that the manual checking of all abnormal blood test results is not worthwhile and our department has discontinued this practice. It has, instead, been emphasised to all doctors that they must review all results of tests that they have requested in patients who are discharged directly from the ED. The responsibility of this lies entirely with the requesting doctor. The middle grade doctors will be eternally grateful at being able to relinquish the task and will also be more likely to benefit patients by spending their additional time on the shop floor.

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Accepted 3 October 2006

Competing interests: None declared.

Differences in trauma team activation criteria used by hospitals in the South West Peninsula

Outcome from major trauma is improved by a multidisciplinary trauma team.[1] The Royal College of Surgeons (RCS) has suggested criteria for activation of the trauma team,[2] although the evidence to support these is limited, and anecdote suggests that criteria vary among similar hospitals. We undertook a cross-sectional survey of trauma team activation (TTA) criteria used by the six hospitals within the South West Peninsula designated to receive cases of major trauma.

The results highlight a wide variation in the criteria used. One hospital used a two-tier activation system; the rest had a single set of

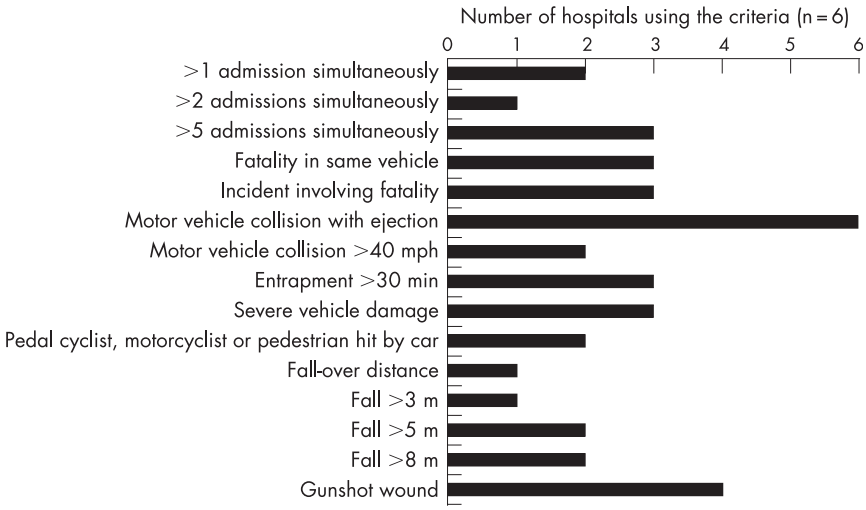

Figure 1 Mechanism of injury criteria.

criteria for TTA. Figure 1 illustrates the variation in mechanistic criteria. Pulse >120/min and oxygen saturations <90% were the most frequently used physiological criteria (67%, n = 4); 67% of hospitals also used systolic hypotension (<90 mm Hg in three hospitals and <100 mm Hg in one hospital). The anatomical criteria again showed disparity, with no criteria being used by more than half of the hospitals. When compared with the RCS recommendations, two hospitals complied and one used RCS criteria along with some locally added elements.

Criteria would ideally be sensitive and specific in their prediction of serious injury and accurately identify those patients who would benefit most from multidisciplinary care. Regional and national standardisation of TTA criteria would optimise patient care and facilitate healthcare practitioner training while providing a firm basis for research and audit of practice. Now is the opportunity for the College of Emergency Medicine to lead trauma care in the UK by developing such evidence-based criteria.

We suggest more widespread use of a two-tier activation system, involving a first tier (a team within the emergency department) activated on the basis of traditional mechanistic criteria, and a second multi-disciplinary tier activated in the presence of additional physiological abnormality. This has been shown to be safe and cost effective, with no adverse influence on outcome in several centres in the US.[3–6]

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doi: 10.1136/emj.2007.047134

Accepted 9 February 2007

Competing interests: None.

References

1 **Petrie D**, Lane P, Stewart TC. An evaluation of patient outcomes comparing trauma team activation versus trauma team activation not activated using TRISS analysis. *J Trauma* 1996;**41**:870–5.
2 **Royal College of Surgeons**. *Better care for the severely injured*. London: RCS, 2000.
3 **Ochsner MG**, Schmidt JA, Rozycki GS, *et al*. The evaluation of a two-tier trauma response system at a major trauma center: is it cost effective and safe? *J Trauma* 1995;**39**: 971–7.
4 **Terregino CA**, Reid JC, Marburger RK, *et al*. Secondary emergency department triage (supertriage) and trauma team activation: effects on resource utilization and patient care. *J Trauma* 1997;**43**:61–4.
5 **Plaisier BR**, Meldon SW, Super DM, *et al*. Effectiveness of a 2-specialty, 2-tiered triage and trauma team activation protocol. *Ann Emerg Med* 1998;**32**:436–41.
6 **Eastes LS**, Norton R, Brand D, *et al*. Outcomes of patients using a tiered trauma response protocol. *J Trauma* 2001;**50**:908–13.

RRETRACTION NOTICE

doi: 10.1136/emj.2006.43307corr1

DUPLICATE PUBLICATION OF SHORT REPORT

We recently published the following short report: Munro PT, Howie N, Gerstenmaier JF. Do peripheral blood cultures taken in the emergency department influence clinical management? *Emerg Med J* 2007;**24**:211–212.

This is a duplicate publication of the same short report also published in the same issue (pages 213–214) and so the above version is being retracted from publication.

The publishers would like to apologise for this error.