

ative recovery. Ryan's paper is important not just for the proposal of accelerated transfer of patients out of the A&E department but also for its clear demonstration that A&E department staff are, with or without a fast tracking system, the key agents in assuring that these priorities are tackled.

The primary problem for elderly patients with femoral fractures is, of course, not the location of, but rather the quality of, their wait for definitive care. The universal scarcity of beds is of fundamental concern to us all at the present time, but it is something over which clinical staff in an A&E department often have little control and which we believe is too often used as an excuse for poor immediate care. In our departmental policy, for instance, patients with suspected proximal femoral fractures are given opiates in a judicious manner (rather than the non-steroidal medication described in Ryan's article, which is associated with acute renal impairment and other serious complications in the elderly²). We also prefer the three-in-one ("triple nerve") block which anaesthetises the femoral, obturator, and lateral cutaneous nerves³ (and not just the femoral nerve as was the case in 17% of Ryan's patients), which then permits comfortable splintage and transfer to a bed. Alternatively, we transfer such patients directly from ambulance stretchers to beds which are "borrowed" if necessary from our short stay observation ward (SSOW) but which could, in other hospitals, be borrowed from the closed wards that clinicians bewail. Occasionally, younger patients (who are better able to tolerate lying on hard trolleys) need to wait a little longer for a SSOW bed to allow more appropriate use of such beds for the infirm and elderly. Finally, when the elderly patients are comfortable, we begin the quest for orthopaedic transfer.

In short, then, Ryan *et al* are to be applauded for establishing a system to reduce delays in transfer but, while frustrating bed shortages and delays in transfer abound, they should not have an exaggerated bearing on the provision of timely, effective, and compassionate care in the A&E department.

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Emergency medicine at a large rock festival

EDITOR,—We were very interested to read the experience of Hewitt, Jarrett and Winter at the Monsters of Rock Festival '92.¹ We have just completed examining our experience at a similar rock music festival held in Cork from 4th to 6th August 1995 (*Feile '95*). This

festival was a three day event attended by 70 000 people. The medical facilities at *Feile '95* were distributed between five first aid posts and one medical centre with facilities for observation and treatment. This centre received referrals from the first aid posts and a small number presented directly. The medical staff consisted of 12 doctors, nine contracted through a private firm and three accident and emergency (A&E) physicians who were from the local health authority. Two A&E nurses staffed the medical centre between 12.00 am and midnight. The cost of the provision of medical services was funded by the organisers of the event.

A total of 1627 individuals required medical attention and their diagnoses are shown in the figure. In contrast to the Monsters of Rock festival, 407 (25%) of attendances were for heat related conditions, while 180 (11%) of those attending required attention after substance abuse (alcohol, Ecstasy, LSD, etc). Eighteen patients were ultimately referred to the A&E services in the city and of these only eight (0.5% of total medical encounters) required hospital inpatient services. The Cork fans were probably a more cheerful bunch in that there were only eight assaults with only one needing head injury observation in the hospital. Perhaps this can be explained by the higher intoxication rate among the devotees

in Cork! On a more serious note, there was a marked absence of sale of items that could be used as missiles. We would therefore support Hewitt *et al* in their call for consideration of what is sold at such festivals. Finally, our experience suggests that provision of on-site medical cover with an observation area is highly desirable. The benefits of such a service have been noted at similar large gatherings on both sides of the Irish sea.^{2 3} There is obviously a need for this type of care and it is highly protective of the local A&E departments and general practitioners.

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Thrower's fractures of the humerus

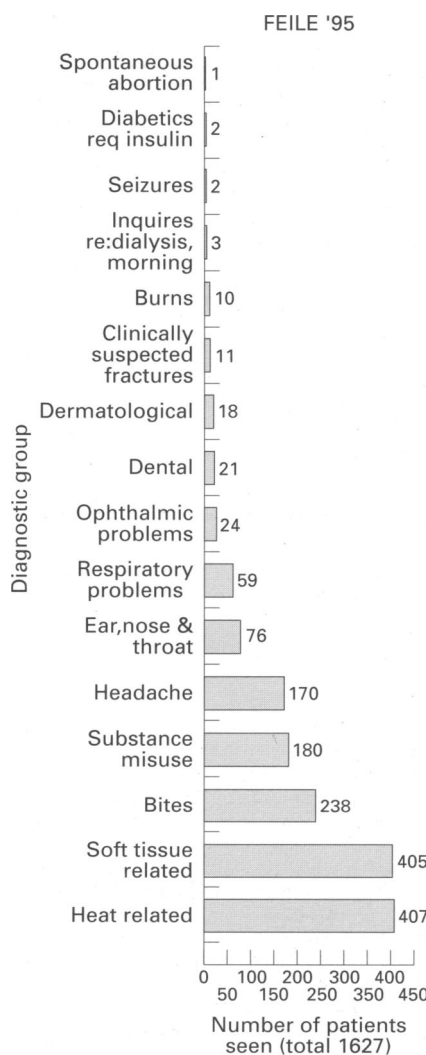
EDITOR,—While the recent paper on thrower's fractures of the humerus from Evans *et al* was most informative, we cannot agree with the explanation offered for the aetiology of the fractures.¹ The forces used by the individual patients were different as evidenced by the case histories and the two differing fracture patterns.

We have treated a 19 year old fit athlete who presented with a fracture identical to that described in case 2, who, after open reduction and secure internal fixation, returned with a fracture of the same configuration six weeks later. It had occurred through the most proximal screw hole of the longer of the reconstruction plates used for fixation. The mechanism of injury was identical on both occasions (a gentle overarm throwing action of a light piece of clothing) and similar to the type of throwing action described in case 2. He had not suffered prodromal symptoms of any type.

The mechanism of injury is related, we believe, to the more proximal attachment of the triceps relative to the biceps, resulting in an extreme form of avulsion injury affecting the whole distal humerus. This explains the oblique anteroposterior fracture pattern without a significant spiral component. The proposed fracture development of Tullos and King may explain fractures where the overarm throwing action is more strenuous and more complex.² The pathogenesis of radial head fractures from high level falls complements their theory but is not relevant to Evans' second case or our patient.³

We would also emphasise to readers the risk of refracture in patients with seemingly strong humeral bone fixed in the standard fashion using either standard 4.5 mm dynamic compression or reconstruction plates.

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Diagnoses of medical encounters at *Feile '95*.