undertaken. We are sure that the authors would concur that the clinical scenario given would not be the appropriate occasion to ''have a go'' with a new device for the first time.

In conclusion, we believe that far more important than ultrasound-guided CVC insertion, is the correct choice of insertion site to avoid those significant risks, which the critically-ill patient would not tolerate.

M Chikungwa, M Lim

Correspondence to: M Chikungwa; mchikungwa@msn.com

doi: 10.1136/emj.2004.015156

Accepted for publication 25 February 2004

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Patients' attitudes toward medical photography in the emergency department

Advances in digital technology have made use of digital images increasingly common for the purposes of medical education.[1] The high turnover of patients in the emergency department, many of whom have striking visual signs makes this an ideal location for digital photography. These images may eventually be used for the purposes of medical education in presentations, and in book or journal format.[2 3] As a consequence patients' images may be seen by the general public on the internet, as many journals now have open access internet sites. From an ethical and legal standpoint it is vital that patients give informed consent for use of images in medical photography, and are aware that such images may be published on the world wide web.[4]

The aim of this pilot study was to investigate patient's attitudes toward medical photography as a guide to consent and usage of digital photography within the emergency department. A patient survey questionnaire was designed to answer whether patients would consent to their image being taken, which part(s) of their body they would consent to being photographed, and whether they would allow these images to be published in a medical book, journal, and/or on the internet.

All patients attending the minors section of an inner city emergency department between 1st January 2004 and 30th April 2004 were eligible for the study. Patients were included if aged over 18 and having a Glasgow coma score of 15. Patients were excluded if in moderate or untreated pain, needed urgent treatment, or were unable to read or understand the questionnaire. All patients were informed that the questionnaire was anonymous and would not affect their treatment. Data was collected by emergency department Senior House Officers and Emergency Nurse Practitioners.

100 patients completed the questionnaire. The results are summarised below:

Q1 Would you consent to a photograph being taken in the Emergency Department of you/part of your body for the purposes of medical education?

Yes 84%, No 16%

21% replied Yes to all forms of consent, 16% replied No to all forms of consent, while 63% replied Yes with reservations for particular forms of consent.

Q2 Would you consent the following body part(s) to be photographed (head, chest, abdomen, limbs and/or genitalia)?

The majority of patients consented for all body areas to be photographed except for genitalia (41% Yes, 59% No) citing invasion of privacy and embarrassment.

Q3 Would you consent to your photo being published in a medical journal, book or internet site?

The majority of patients gave consent for publication of images in a medical journal (71%), book (70%), but were more likely to refuse consent for use of images on internet medical sites (47% Yes, 53% No or unsure).

In determining the attitudes of patients presenting in an inner city London emergency department regarding the usage of photography, we found that the majority of patients were amenable to having their images used for the purposes of medical education. The exceptions to this were the picturing of genitalia and the usage of any images on internet medical sites/journals.

The findings of this pilot study are limited to data collection in a single emergency department in central London. A particular flaw of this survey is the lack of correlation between age, sex, ethnicity, and consent for photography. Further study is ongoing to investigate this.

There have been no studies published about patients' opinions regarding medical photography to date. The importance of obtaining consent for publication of patient images and concealment of identifying features has been stressed previously.[5] This questionnaire study emphasises the need to investigate patients' beliefs and concerns prior to consent.

A Cheung, M Al-Ausi, I Hathorn, J Hyam, P Jaye

Emergency Department, St Thomas' Hospital, UK

Correspondence to: Peter Jaye, Consultant in Emergency Medicine, St Thomas' Hospital, Lambeth Palace Road, London SE1 7RH, UK; peter.jaye@gstt.nhs.uk

doi: 10.1136/emj.2004.019893

Accepted for publication 12 October 2004

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Unnecessary Tetanus boosters in the ED

It is recommended that five doses of tetanus toxoid provide lifelong immunity and 10 yearly doses are not required beyond this.[1] National immunisation against tetanus began in 1961, providing five doses (three in infancy, one preschool and one on leaving school).[2] Coverage is high, with uptake over 90% since 1990.[2] Therefore, the majority of the population under the age of 40 are fully immunised against tetanus.

Td (tetanus toxoid/low dose diphtheria) vaccine is often administered in the Emergency Department (ED) following a wound or burn based upon the patient's recollection of their immunisation history. Many patients and staff may believe that doses should still be given every 10 years.

During summer 2004, an audit of tetanus immunisation was carried out at our department. The records of 103 patients who had received Td in the ED were scrutinised and a questionnaire was sent to the patient's GP requesting information about the patient's tetanus immunisation history before the dose given in the ED. Information was received in 99 patients (96% response). In 34/99 primary care records showed the patient was fully immunised before the dose given in the ED. One patient had received eight doses before the ED dose and two patients had been immunised less than 1 year before the ED dose. In 35/99 records suggested that the patient was not fully immunised. However, in this group few records were held before the early 1990's and it is possible some may have had five previous doses. In 30/99 there were no tetanus immunisation records. In 80/99 no features suggesting the wound was tetanus prone were recorded.

These findings have caused us to feel that some doses of Td are unnecessary. Patient's recollections of their immunisation history may be unreliable. We have recommended that during working hours, the patient's general practice should be contacted to check immunisation records. Out of hours, if the patient is under the age of 40 and the wound is not tetanus prone (as defined in DoH Guidance[1]), the general practice should be contacted as soon as possible and the immunisation history checked before administering Td.

However, we would like to emphasize that wound management is paramount, and that where tetanus is a risk in a patient who is not fully immunised, a tetanus booster will not provide effective protection against tetanus. In these instances, tetanus immunoglobulin (TIG) also needs to be considered (and is essential for tetanus prone wounds). In the elderly and other high-risk groups—for example, intravenous drug abusers—the