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no next of kin, and two with known contraindications. In addition, 11 patients were missed by the study. Of the remaining 25 patients, consent was given for nine and nine pairs of corneas were retrieved for storage.

One questionnaire was incorrectly completed, leaving 24 for analysis. Twenty one relatives thought it was appropriate to be approached regarding corneal donation; 23 were not distressed by the request.

Only four out of 24 patients carried a donor card or had expressed a wish to their relatives to donate their organs and in each case this included corneas. These data may add to the political debate on the validity of donor cards and the need for an opt out policy. Of the nine patients who donated corneas, three carried a donor card.

Comment

The study shows that an active policy for corneal donation in accident and emergency departments can have a dramatic effect on retrieval rates of corneas. The retrieval rate of 36% (25% if the 11 missed patients are included) compares favourably with rates found in previous studies.³⁻⁵ The rate is also a significant increase from the 1% of the previous year (95% confidence difference 24% (10% to 38%); $P = 0.001$).

Many factors may be responsible for the 11 patients missed by the study. Despite training, staff may have felt it was inappropriate to approach relatives at this time of grief, or the department may have been busy, causing concern that the procedure would be time consuming. Exclusion criteria may have been known but not documented in the case notes at the time of death.

More work is needed to educate the public and staff about corneal donation. In January 1999 the Manchester Eye Bank was unable to issue any corneas for grafting because of a shortage. In 1998, 28 pairs of corneas were retrieved in the west of Scotland. Projecting our results for one year, we would expect to double the number of corneas donated in the west of Scotland simply by implementing this policy in one accident and emergency department. Accident and emergency is clearly a specialty that could help resolve the national shortage of donor corneal tissue.

We thank all the medical and nursing staff in the Accident and Emergency Department, Victoria Infirmary, Glasgow, for their help and support during this study.

Contributors: JL had the original idea for the study, coordinating it, participating in data collection and interpretation, and writing the paper. He is also the guarantor. DW participated in the design of the study and data collection. DAWR participated in the design of the study. FR participated in the design of the study, data collection and interpretation, and writing the paper.

Funding: None.

Competing interests: None declared.

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(Accepted 22 May 2000)

A memorable patient Not an ordinary sore throat

It was a busy Saturday morning surgery. The patient was a 52 year old Menorcan waiter whom I knew vaguely, having seen him a few times when his marriage was in trouble. His new partner made the call at about 10 30 am when there were still 15 patients to see and three visits in the book. He had been down to the surgery the previous afternoon with a sore throat without a cough, and had been prescribed penicillin by one of my partners. His girlfriend said that he was no better and was having trouble breathing. I asked if he could come down to the surgery, to which the reply was: "No, he finds it very difficult to get down the stairs." I thought it best to speak directly to the patient.

He apparently had a slight sore throat, but was not wheezy, and could talk normally with no obvious breathing problem. There was no history of asthma or allergy, and he said that he felt fine in bed but could really not get down the stairs; he even found it an effort to get to the lavatory. Somewhat reluctantly I said that I would visit after surgery.

He looked fine lying in bed, and conversed easily with no dyspnoea or stridor. "I'm sorry to call you out, Doctor, but I cannot get down the stairs."

Impatiently, I asked him to sit up so that I could look in his throat and examine his chest.

"I can't, Doctor."

"Of course you can," I said, firmly helping him upright, at which moment he choked and gasped, and threw himself back flat on the bed. I asked him to try again and the same thing happened. He seemed to be unable to breathe in the vertical position but was fine lying flat.

I examined him flat on the bed: the pharynx was a little red, but there was no quinsy or obvious swelling, and no cervical lymphadenopathy. He had a slight temperature. The lungs were clear and there was no asymmetry in expansion. He could breathe equally well lying on the right or the left, or on his back.

Finally, taking him seriously, I asked if he had any problems in the past with his throat, and the reply was that when he was a child he had had some throat polyps removed.

I gave him some steroids and arranged to admit him, with a provisional anatomical diagnosis, and with strict instructions to the ambulance crew to keep him flat when going down the stairs. The ear, nose, and throat registrar had said: "Send him in—it sounds absolutely fascinating."

Initial laryngoscopy proved difficult, but after 48 hours of steroids and antibiotics he had his posterior laryngeal polyp excised—arising from the arytenoids. Results of histology were benign.

The usual response to laryngeal obstruction—usually caused by epiglottic or pharyngeal swelling—is to sit up and forward. This man had significant laryngeal obstruction from a posterior polyp, which flopped in and out of the glottic opening as he changed position from horizontal to vertical and back again.

The image of my patient's reaction to "iatrogenic" laryngeal obstruction when I forced him into the vertical position to examine him will certainly live with me for a long time.

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