A SERIES OF 1,817 PATIENTS SEEN IN A CASUALTY DEPARTMENT

BY

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Many patients go to the casualty department of this hospital as they would to their own doctor's surgery. At the same time, the casualty officer has the resources of a large hospital at his disposal. It therefore seemed worth while to analyse complaints, diagnosis, and treatment of a large series of such patients.

Material.—The hospital is situated in Central London, in an area occupied chiefly by tailoring workshops, and very near the polyglot Soho district. The series consists of all patients seen by me between September, 1954, and January, 1955. All patients with obviously "surgical" conditions, such as infected hands and road accidents, are sent to a separate surgical department. Virtually all other patients are seen by one of the two casualty medical officers.

Results

Total attendances in my room during the specified period numbered 1,817. Of these, 975 were by new patients, of roughly equal sex distribution and very mixed nationality. The average age of the new patients was 36.2 years, of the old patients 39.5 years.

Of the 975 new patients, 11 were sent up by their own doctors, 104 by other hospital departments, 23 by a sister or foreman at their place of work, 52 came by ambulance, 43 had no doctor of their own, and 4 said their doctor was not available that day. In answer to the question, "Why didn't you go to your own doctor first?" 38 patients said they were dissatisfied with him. This leaves 700 out of 975 unaccounted for. The great majority of these were not in any sense emergencies. Most of them had no clear explanation of their preference for hospital treatment, though on further questioning certain answers tended to occur frequently. The commonest reply was that it was more convenient to come to the hospital than go to the surgery. A few were genuinely surprised when I told them that the proper course was to consult their own practitioner first. This leaves those patients—quite a considerable number—who, without admitting that they did not trust their own doctor, indicated that they thought that better treatment would be meted out to them in hospital. The two chief factors in this group were the feeling that x-ray examinations were more readily ordered in hospital, and that a hospital doctor would carry out a more thorough examination. Mothers who brought their children often gave this last answer.

The symptoms of the 975 new patients are analysed in Table I, which also shows the final diagnosis in each case. Only the commoner symptoms and diagnoses have been listed in detail. As can be seen, pain is the greatest single problem encountered in this series. Of 327 complaints of pain, no organic cause was thought to be present on 85 occasions (26%). Other complaints, such as feelings of lassitude and transient loss of consciousness, have a much higher incidence of "no organic cause found" (see Table I). Of the 669 complaints analysed, no organic abnormality could be found in 182 cases (27%).

Of the 52 patients who arrived by ambulance, 31 complained of a transient loss of consciousness or of sudden weakness or faintness; of these, six were epileptics and two were suffering from carcinomatosis. Of the 52 patients, 23 had nothing seriously wrong with them, and certainly did not need an ambulance. Nine of the 52 were admitted to hospital.

TABLE I.—Symptoms and Diagnosis

Symptom	Diagnosis	No.
Abdominal pain (142)	No organic cause found Acute indigestion Peptic ulcer Dysmenorrhoea Salpingitis Constipation Acute surgical conditions Urinary disorders Trauma to abdominal wall Others (6 diagnoses)	36 (25.3%) 22 (15.5%) 21 (14.7%) 9 (6.3%) 8 (5.6%) 8 7 7 7 17
Pain in back (44)	Pain of muscular or ligamentous origin (back strain) No organic cause found Others (including 4 cases of lumbar disk prolapse)	15 (34.1%) 11 (25%) 18
Pain in chest (41)	No organic cause found Pain of cardiac origin Bruise Others (8 diagnoses)	15 (39%) 5 (13%) 5 16
Limb pain (35)	No organic cause found Osteoarthritis Lumbar disk prolapse Cervical disk prolapse Others (7 diagnoses)	10 (28.6%) 8 4 4 9
Pain in head (25)	Acute virus infection No organic cause found Others (6 diagnoses)	9 (36%) 6 (24%) 10
Other pains	— (no organic cause found)	40 7)
Rash (108)	Sensitivity reactions Impetigo Chronic non-allergic eczema Seborrhoeic dermatitis Bites Acne Scabies Others	17 (15.7%) 12 (11.1%) 11 (10.2%) 10 (9.2%) 9 7 6 36
Weakness or faintness of sudden onset (58)	No organic cause found Acute virus infection Carcinomatosis Others (6 diagnoses)	36 (62%) 13 (22.4%) 2 7
Bleeding	— (no cause found)	57 18)
Cough (50)	Infection of upper respiratory tract No cause found Chronic bronchitis Acute bronchitis Others (5 diagnoses)	19 (38%) 12 (24%) 11 (22%) 3 5
Transient loss of consciousness (26)	No organic cause found Epilepsy Others (5 diagnoses)	13 (50%) 7 6
Dyspnoea (18)	Chronic respiratory insufficiency Bronchial asthma Heart failure No organic cause found Anaemia Others	5 3 3 3 2 2
Chronic lassitude (13)	No organic cause found Anaemia Others	8 2 3
Giddiness (12)	No organic cause found Others	7 5

Investigations.—A total of 334 investigations were ordered for 288 of the new patients—that is, nearly every third new patient: 133 chest x-ray examinations, 71 other plain x-ray examinations, 13 contrast-medium x-ray films, 43 blood tests, and 74 miscellaneous tests. Routine urine tests and faecal occult blood determinations were done by me where indicated, and are not included in these figures.

A record was kept of all prescriptions: 937 were issued for a total of 1,817 attendances; 509 of the prescriptions went to new patients. Table II shows what was prescribed.

TABLE II

Prescription	No.
Local applications	272
Analgesics (mostly codeine and A.P.C.)	238
Indigestion mixtures (mostly antacids)	127
Barbiturates (mostly phenobarbitone for ulcer patients)	93
Iron	36
Antihistamines	36
Sulphonamides	44
Penicillin	24
Others	14

Placebos were prescribed on 53 occasions.

Discussion and Conclusions

The eagerness of patients for "special tests" is well known, and was further confirmed by this series. Our casualty officers also have more time than most general practitioners to examine their patients, and this, together with the whole atmosphere of a busy hospital department, no doubt lured many patients. While every effort was always made to return the patient to the care of his doctor, obviously this could only rarely be done without examining, and often further investigating, the patient first.

This report emphasizes the prime importance of pain as a presenting symptom. The treatment of those in whom no cause can be found for the pain (26% in this series) is difficult and in my experience unsatisfactory. The size of this particular problem demands more attention than has been given to it so far. Pougher (1955) found that 36.2% of 500 consecutive patients seen by him in his practice were suffering from "neurosis." In the present series no organic cause could be found to account for 27% of 669 symptoms.* Pougher lists 684 symptoms mentioned by his neurotics; there were 213 complaints of pain. Other symptoms, such as weakness, dizziness, and faintness, also figure prominently on his list. It is interesting that in my series far fewer patients came with indefinite complaints such as "depression" or "irritability" than did so in Pougher's series; this may be due to a desire on the part of patients to dramatize their story when attending hospital. Richards (1956) mentions an incidence of 30% for psychogenic disorders in general practice. Analysis of the records from ten general practices over two years (General Practitioners' Records, 1956) shows that approximately 13% of all consultations were sought by patients suffering from frank psychoneurosis.

Analysis of the 52 patients who came by ambulance throws an interesting sidelight on the abuse of this service; 23 of these patients did not need private transport of any sort.

Summary

The source, symptoms, diagnosis, and treatment of 975 consecutive new casualty patients have been analysed: 327 of them complained of pain.

In 27% of all analysed symptoms no definite organic cause could be found.

My thanks are due to Dr. D. G. James for his constant encouragement and criticism. I am also grateful to the Medical Committee of the Middlesex Hospital for permission to publish this article; all opinions expressed in it are naturally my own and not necessarily those of the committee.

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THE MOUTH-BREATHING

At a meeting of the Section of Paediatrics of the Royal Society of Medicine on October 25 "The Mouth-Breather" was discussed. Members of the Sections of Laryngology and of Odontology were invited to attend.

Mr. E. GWYNNE-EVANS, surgeon in charge of the upper respiratory diseases clinic at the Victoria Hospital for Children, Chelsea, began by noting that nasal breathing depended on both the patency of the nasal passages and the efficiency of the oro-pharyngeal musculature. Failure of the oro-pharyngeal muscles was a commoner cause of mouth-breathing in children than nasal obstruction due to enlargement of the adenoids, and of the various types of nasal obstruction Mr. Gwynne-Evans thought swelling of the anterior nasal mucosa from allergic vasomotor rhinitis also a more frequent cause in children than adenoidal enlargement.

*The difference between this figure and the total number of new patients (975) is made up of those with uncommon symptoms (occurring less than 10 times in the whole series) and those referred for only routine examination.

Significance of the Adenoid Facies

In infants and young children there was a very strong natural instinct towards nasal breathing, and, provided that serious degrees of nasal obstruction were excluded—or corrected—the propensity to nasal breathing tended to overcome failure of the oro-pharyngeal muscles. He was quite certain that in the vast majority of children with the so-called adenoid facies the adenoids were not at fault. These children with long faces, protruding upper teeth and receding chins, and their apparently vacant expressions did not suffer from nasal obstruction, nor were they mentally dull, nor would they develop any permanent nasal, facial, or oral deformities. Their facies was a normal type of natural physiognomy related to hereditary factors rather than to any structural defects.

Professor C. F. BALLARD, professor of orthodontics at the Institute of Dental Surgery, London University, also considered that mouth-breathing never resulted in oral deformities or led to the production of the adenoid facies. His own studies over the past 15 years had convinced him that this facies was a normal phase in the development of a certain type of child and that it was probably an ectomorphic characteristic, possibly related to other features such as asthma and the periodic syndrome. The facies was uninfluenced by any type of remedial exercise or oral appliance—in fact the unnecessary institution of these was very likely to lead to frustration and mental distress in both child and parents.

There was no special morphological type associated with mouth-breathing. Most children with the "open-lip" type of oral posture did not breathe through their mouths, while on the other hand some with a "closed-lip" posture did so. Oral configuration was unrelated to the state of the adenoids, and in his opinion enlargement of the adenoids was never responsible for deformities of the bone structure of the mouth.

In the management of the mouth-breather the first thing was to look for any obvious and definite causes of nasal obstruction and to treat them if present. If there was no obstruction—and there seldom was—then there was no need to embark on any treatment in the young child. Orthodontic treatment might be necessary later, but usually not until around 12 years of age. The majority of children with an adenoid facies would eventually grow out of it.

THYROID HORMONES

At a sectional meeting of the Manchester Medical Society on October 23 Professor N. F. MACLAGAN (Westminster Hospital) reviewed recent work on the thyroid hormones. It was a complex situation, he said. Since the characterization of thyroxine by Dr. (now Sir Charles) Harington in 1926, work inspired by Mrs. R. V. Pitt-Rivers in Britain and by Professor J. Roche in France had led during the last five years to the discovery of four or five other substances which were at present candidates for the position of "the" thyroid hormone. Triiodothyronine had, perhaps, the strongest claim, since it was effective in the smallest dosage, less than 0.1 mg. per day sufficing for the control of human myxoedema. Thyroxine itself was thought to require conversion to some other compound, both because of its relatively long latent period and on account of work with "anti-thyroxine" compounds, which antagonize the metabolic effects of thyroxine by inhibiting its deiodination. 3:3'-Diiodothyronine required consideration, and tetra- and tri-iodothyroacetic acids were more recent competitors for pre-eminence, since they acted with a shorter latent period than the thyronine derivatives. However, larger doses were required, and their rapidity of action was better established in subcellular preparations than in the intact animal or patient.