References

- 1 Stables G, Quigley G, Basu S, *et al.* An unusual case of a compound depressed skull fracture after an assault with a stiletto heel. *EMJ* 2005;22:303-4.
- 2 Ahmed RH. "Stiletto heel" penetrating fractures of the skull. *BMJ* 1964;5412:801-2.

Reply: complications following attempted rapid sequence intubation

Dr Hulme raises several important points. First, rapid sequence intubation (RSI) is not to be taken lightly even by experienced physicians. It is fraught with danger that can be disastrous.

Second, I fully acknowledge that the second dose of succinylcholine should not have been given, but do not feel that this would have played out any differently. This patient had been losing his airway even before attempted RSI, and would have required one form of definitive airway. As stated in the article, several attempts by the attending anaesthesiologist at nasal intubation were also unsuccessful.

I also acknowledge that malignant hyperthermia should be considered in the differential diagnosis for masseter spasm. However, as stated in the discussion, this patient had no other cardinal manifestations of malignant hyperthermia. Unfortunately no biopsy was performed, so we will never know if he was susceptible or not.

Finally, discontinuing anaesthesia is appropriate during elective procedures (as stated in the article); however, this is not always prudent in emergent cases.

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Treatment of epistaxis in the emergency department

I read with interest Leong *et al.*'s article on the management of epistaxis¹ and I would like to add some tips that I would consider useful.

In the treatment of "active" anterior epistaxis, merely spraying the anterior cavity with a combination vasoconstrictor and local anaesthetic is often not enough to stem the bleeding. Using cotton wool, you can form a wick of about 5 cms long, and, after soaking

it in a solution of constrictor/anaesthetic, apply it with a Tilley's forceps into the bleeding nasal cavity. Ask the patient to apply digital pressure to the nose for about 10 minutes. The increased contact to the bleeding point in Little's area is more likely to stem the bleeding, and can then be localised and cauterised.

The "scorched earth" technique of cauterising a general area in the hope of stopping the bleed is not to be entertained as there is increased risk of septal cartilage necrosis. Using a torch and not a headlamp, and failure to use a nasal speculum, contributes to the aforementioned. If a bleeding point cannot be identified, cautery should not be attempted. The origin of the bleed might be posterior.

It is advisable to discharge patients with anterior epistaxis (that have been successfully treated) with an ointment/cream. If your department does not have Naseptin, you can advise the patient to put Vaseline on a cotton bud and gently roll it onto the affected area a couple of times a day. This stops the scab from drying out, becoming itchy, and then picked off prematurely, leading to rebleeding.

The digital pressure applied to the nose (fig 1b of article¹) is better applied with the fingers in a flexed, fist like position and the dorsal aspect of the middle phalanx of the index finger resting on the maxilla. The pinch action is then completed by applying the palmar aspect of the interphalangeal joint area of the thumb to the lower part of the nose on the other side.

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Reference

- 1 Leong SC, Roe RJ, Karkanevatos A. No frills management of epistaxis. *Emerg Med J* 2005;22:470-2.

C-reactive protein in the emergency department

I read with interest the report of a case of pneumococcal meningitis presenting as ankle pain.¹ Although it discussed the management of an interesting and highly unusual patient, I found it hard to follow the logic of the conclusion that "CRP is an important investigation for emergency departments".

As the authors state, C-reactive protein (CRP) is an acute phase protein. Levels of CRP are elevated in the serum of patients with acute and chronic inflammatory, infective, and neoplastic disorders. A recent systematic review by van der Meer *et al.*² examined the evidence pertaining to the contribution of CRP in patients with lower respiratory tract infections (such as pneumococcus). They found in 12 studies reviewed that the relation between an elevated CRP and a bacterial aetiology of the infection was poor: sensitivity ranged from 8-99% and specificity from 27-95%. Other studies in which CRP has been used as a diagnostic tool for other conditions have echoed these findings.

An audit performed by myself in a large teaching hospital emergency department found that between 250 and 500 CRP studies were being requested per month. These were being requested indiscriminately for the full spectrum of presenting conditions, from chest and abdominal pain to one patient that presented with a stab wound! Although individual tests were relatively cheap, because of the numbers being requested the total annual cost to the department was almost £13 000. As a literature review at the time found no evidence to support the use of CRP in the emergency department, departmental policy was altered to prevent the requesting of CRP as routine.

I suspect even the most skilled of emergency physicians may have found the diagnosis of pneumococcal meningitis based on a presentation of ankle pain difficult, with or without a CRP result. As CRP lacks the diagnostic specificity to be of help in the initial assessment of the patient, I feel that it is misleading to advocate its widespread use based on this case alone.

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References

- 1 Huntley JS, Kelly MB. C-reactive protein: a valuable acute investigation. A case of pneumococcal meningitis presenting as ankle pain. *Emerg Med J* 2005;22:602-3.
- 2 Van der Meer V, Neven AK, *et al.* Diagnostic value of C reactive protein in infections of the lower respiratory tract: a systematic review. *BMJ* 2005;331:26-9.