PostScript

LETTERS

What goes on in a paediatric resuscitation room?

We performed an activity analysis of the resuscitation room in our inner city paediatric emergency department. Data were entered prospectively onto a computer in the room by the nurse or doctor caring for each patient. Patient capture was checked against a separate audit in progress, and data retrospectively entered for missed patients ($n = 7$). The database was similar to that used in our adult resuscitation room,¹ but modified for paediatric use.

Between November 2003 and October 2004, 21 207 new patients attended the paediatric emergency department and 139 (0.7%) of these passed through resuscitation. This has implications when planning new facilities, and suggests that flexible or shared resuscitation facilities may be appropriate in units seeing similar numbers of children but where adults also attend.

The diagnosis of the resuscitation room patients is shown in table 1. The breadth of conditions is striking, but the data also tell us where education should be focused.

In the prehospital phase, one of these children was intubated, three had an intraosseous needle inserted, and one was defibrillated. This has implications for pre-hospital training and skills maintenance. Similarly, 17 children (12%) were intubated in resuscitation; four of these were in cardiac arrest, and drugs were used in only 13. This equates to one child per month, and suggests that it would be difficult for emergency physicians to learn and maintain advanced paediatric airway skills, even in a children's hospital.

The database is easy to set up and use. We found it useful for audit and governance purposes. We would be happy to answer any enquiries, or supply a copy on request.

Table 1 Diagnosis of children managed in the resuscitation room

Diagnosis	Number (%)
Seizures	31 (22%)
Trauma	22 (16%)
Apnoea/floppy spell	9 (6%)
Bronchiolitis	9 (6%)
Arrhythmia	8 (6%)
Asthma	7 (5%)
Cardiac arrest	7 (5%)
Burns/inhalation	6 (4%)
Pneumonia	6 (4%)
Anaphylaxis	5 (4%)
Diabetic Ketoacidosis	4 (3%)
Croup	3 (2%)
Sepsis	3 (2%)
Meningococcaemia	3 (2%)
Congenital heart disease	2 (2%)
Procedure	2 (2%)
Other	12 (9%)

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Ethics approval was not thought necessary at the time of activity analysis. The data were already routinely collected as part of several hospital audits and the database was also designed to unify the collection process.

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Reference

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Comparative elbow radiographs in children

Trauma to the developing skeleton in children is common, and elbow fractures account for 20–40% of all fractures. It has been demonstrated that the initial physical examination of upper extremities for gross deformity and point tenderness has a diagnostic sensitivity and specificity of 81% and 82%, respectively,¹ leaving a significant percentage of fractures dependent on x ray for diagnosis. However, fractures of the elbow are still some of the most frequently overlooked fractures in emergency medicine because of the complex radiographic anatomy of the developing elbow. Normal growth plates may be mistaken for fracture lines, and minimally displaced fractures are often under diagnosed. There is also considerable individual variation in the development of the ossification centres, which can be confusing.

It has been suggested that comparison radiographic view of the unaffected elbow may be helpful in evaluating elbow fractures,² but the routine use on every child with elbow injury is unjustifiable in terms of resources and increased radiation exposure for the child. It has even been shown that such comparison radiographs did not improve diagnostic accuracy in elbow trauma.³

To overcome some of these problems in our hospital, we have compiled two sets of normal elbow radiographs of children, one of each sex, encompassing ages one to eighteen years. They show serial growth changes taking place in the elbow from infancy to adulthood. Furthermore, a separate collection of abnormal radiographs has also been obtained to demonstrate common elbow injuries. In our experience, junior doctors have found them useful in aiding diagnosis when consultation with our radiology colleagues is impossible. It is our belief that this method will help to enhance rates of accurate diagnoses of elbow injuries, in

combination with physical examination findings and radiographs of the injured elbow.

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- 2 Fick DS, Lyons TA. Interpreting elbow radiographs in children. *Am Fam Physician* 1997;55(4):1278–82.
- 3 Chacon D, Kisson N, Brown T, et al. Use of comparison radiographs in the diagnosis of traumatic injuries of the elbow. *Ann Emerg Med* 1992;21(8):895–9.

Stilettoed in the sixties

One of the wonders of emergency medicine is that there are almost as many different causes of injury as there are injury types. It is therefore not surprising that there are a myriad of case reports in the literature describing unusual objects causing injury. However, some stories have already been told.

I read the case report by Stables *et al*¹ entitled "An unusual case of a compound depressed skull fracture after an assault with a stiletto heel" in *EMJ*, which claims to be the first, and was struck with the thought that this must have been described before. How could we have come through "the Swinging 60s" without this incident having occurred? Indeed, after a very brief search of "Google" using the keywords "skull fracture" and "stiletto heel" from the article, the third result is of a case report in the *BMJ* by Ahmed on "Stiletto heel penetrating fractures of the skull" dated 1964.²

This highlights two important points. First, it is important to remember that the regular Medline database only includes articles from 1966 to the present day, and it is necessary to search OldMedline for articles prior to 1966, or use Google as an obliging alternative.

Second, don't aggravate a girl with stiletto heels!

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