Flying Squads for Road Accidents

SIR,—There recently has been considerable controversy both public and private over the attendance of doctors at the site of serious accidents. In order to fulfil this gap in medical care (*Supplement,* 8 May, p. 91) several flying squads are in existence, and these fall into three large groups—general practitioner flying squads, casualty department flying squads, and hospital flying squads. The latter can be dismissed rapidly since they almost never function except in a major catastrophe.

There are several general practitioner flying squad services, and notably that in Richmond, Yorkshire, has demonstrated what can be done with enthusiasm and effort. They undoubtedly save lives and decrease morbidity, but in my opinion could give an even higher standard of care if they had the necessary resources.

In Derby a flying squad was originally founded in 1955, and has been functioning increasingly successfully since that time. Its organization, etc., has been previously described,[1] and this is basically unchanged, although it is being continuously improved. Briefly, it is an accident flying squad which is based on the casualty department at Derbyshire Royal Infirmary. It consists of a casualty surgeon, an anaesthetist, and a trained nurse, who are always available, with a comprehensive range of surgical, anaesthetic, and resuscitation equipment to travel to any emergency scene. Perhaps I can quote a recent patient who, but for the existence and efficiency of this squad, would inevitably have died before reaching hospital.

At 1.55 p.m. on 1 June the flying squad was called by the ambulance service to the scene of a road traffic accident since the patient was seriously ill with neck injuries. On arrival at 2.02 p.m. the patient was found to be a motor cyclist of 19 years who had collided with a plate glass window. He was lying on his back unconscious in a large pool of blood which was running down the gutter to a drain some 10 yards away. He was pale with no palpable pulses or audible heart sounds and no respiration; his pupils were small and unreacting; there was still profuse blood oozing from the gaping three inch laceration in his right anterior neck region.

A drip was rapidly inserted and plasma/macrodex infusion begun under pressure. Cardiac massage was started, and the patient intubated and ventilated with an Ambu bag (oxygen being entrained). A police car was despatched for some O Rhesus-negative blood. Every bleeding point in his neck was clamped with artery forceps (eight being eventually left in situ). After approximately 2 litres of fluid had been infused in under 10 minutes a slow pulse became palpable. The bradycardia speeded steadily until he had a good strong rapid pulse, and after some 20 minutes of resuscitation he began to breathe spontaneously. He was given 1 litre of blood and only after this time was he transferred to the ambulance and thence comfortably to the hospital casualty department.

On arrival his B.P. was 160/80 mm Hg and pulse 84/min, he was breathing spontaneously, and moving his right side but not his left. He was taken to theatre and his completely split jugular vein ligated, the carotid artery being intact. His right vagus nerve had been divided together with several small arteries. Some four days after the accident his only residue is a recovering mild left hemiplegia.

We are continually seeing such cases but often they are not so successful or clearcut as the above. Without our flying squad he could not have survived, and I feel he is the complete justification for our service. Medical personnel attending accident victims must be well equipped and well versed in the drastic resuscitation techniques necessary for the survival of such seriously injured patients.—I am, etc.,

KEITH LITTLE

Derbyshire Royal Infirmary,
Derby

1 Collins, J., *British Medical Journal,* 1966, 2, 578.

Infectiousness of Glandular Fever

SIR,—As glandular fever is usually considered an infectious disease it is surprising that there are so few reported cases occurring in both husband and wife. This happened recently within my practice in two normally healthy individuals. The three children aged 5, 2, and 1, have so far not been affected. Because of the difficulty of positively identifying a causal organism, achieving artificial transmission of the disease, detecting a carrier or an immune state, and establishing an incubation period, I feel that it is of interest to describe this "mini epidemic."

The husband, aged 31, attended surgery with a week's history of malaise. Four days later he was in bed with fever, and had developed a generalized lymph node enlargement. By then the laboratory had been able to report a leucocytosis with typical mononuclear cells and a positive Monospot test. After a short course of prednisone he quickly felt better and was able to return to work after 14 days, although there were still some palpably enlarged cervical nodes.

Just over seven weeks later I was called to his 28-year-old wife who had a high temperature, frontal headache, and sore throat of two days' duration. A diagnosis of frontal sinusitis was made and oral ampicillin started. After two days she was no better and she had an acute follicular tonsillitis. A course of twice daily penicillin injections was begun. However, after a further two days she was still acutely ill with a persistently high temperature. A throat swab taken two days previously revealed no pathogens, but she had developed an enlarged right tonsillor node on this the sixth day of her illness. Examination of the blood showed typical mononuclear cells and a positive Monospot test. Next day there was splenic enlargement with generalized lymphadenopathy and she required prednisone for several weeks to suppress her symptoms.

The interval between the husband's first symptoms and those of his wife was 63 days. I would be interested to have details of any other two similar cases occurring in close contacts which might help to establish an incubation period for glandular fever, otherwise known as infectious mononucleosis.—I am, etc.,

RICHARD M. WHITTINGTON

Four Oaks,
Warwicks

Eczema and Detergents

SIR,—I have recently read Dr. D. Blair Macaulay's booklet on allergy produced under the auspices of the B.M.A.[1] While there is much in this work to be commended it is unfortunate that in referring to detergents as a cause of eczema he implies that this eczema is due to an antigen-antibody mediated allergic response. That this is done repeatedly implies a lack of understanding of the conceptual differences between contact irritancy and contact allergy.

True cutaneous allergy to detergents is, of course, very rare indeed, a fact that I trust will not surprise Dr. Blair Macaulay one jot.—I am, etc.,

F. A. IVE

Department of Dermatology,
Dryburn Hospital,
Durham

1 Macaulay, D. B., *You and Your Allergy.* London, Family Doctor, 1971.

Deaths from Tuberculosis

SIR,—Your leading article (22 May, p. 419) on "Deaths from Tuberculosis" is timely, considering the implementation of the Local Authority Services Act (1970). Good results in the control of tuberculosis are still dependent on fully trained health visitors, especially in areas where there are high rates of immigration, bad housing, etc. Their local knowledge is invaluable in seeking out infectious patients and their contacts from obscure lodging houses; their skill in supervising effective chemotherapy at home and in ensuring regular follow up at chest clinics is proverbial. In my opinion, any reduction in their numbers or quality would be premature.

The Report of the Research Committee of the British Thoracic and Tuberculosis Association on tuberculosis mortality in Britain[1] showed that a high proportion of deaths was due to failure to follow straightforward clinical and administrative procedures. I am reminded of how the breakdown of communications delayed successful therapy in another type of mycobacterial infection, as related in the fifth chapter of the Second Book of Kings, verses 1-14. This account is a classical example of the tactful approach, which chest clinics still possess by virtue of their health visitors.

With the concept of the "community physician" playing an increasing part in the coordination of health services, I believe that it behoves chest physicians to try to make sure that the needs of the more vulnerable sections of the population are not neglected for the sake of administrative unity.—I am, etc.,

R. A. L. AGNEW

Liverpool Central Chest Service,
Liverpool

1 British Thoracic and Tuberculosis Association, *Tubercle,* 1971, 52, 1.

Serum Transaminases during Salicylate Therapy

SIR,—I found the observations of Dr. A. S. Russell and others (22 May, p. 428) that prolonged salicylate therapy may cause an increase in some serum enzymes most interesting.

I have recently measured the serum

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