

practical procedures before they can graduate. Only basic and advanced life support, venesection, and inserting an intra-venous line are listed in the draft document, and medical schools will probably ask the council to extend this list. The council is to be commended for recognising that such skills need to be taught and tested. Their inclusion should help to reduce the stress felt by junior house officers expected to perform unfamiliar procedures with inadequate supervision on acutely ill patients in the middle of the night.

With their emphasis on reduced factual content, self directed learning, integration of traditional subjects, and training in practical skills, these draft recommendations should help to overcome many of the problems of traditional medical courses. This will happen, however, only if the General Medical Council is committed to ensuring that its recommendations are acted on. It has limited powers to enforce its recommendations, and those it has, like withdrawing recognition from a course, are draconian. It should

realise, however, that there is now a groundswell of approval for the ideas contained in its latest document and should take that as a mandate for their enforcement. When the council issues its definitive document it must be accompanied by a clearly defined timetable for implementation and a firm statement that schools failing to achieve this will be penalised.

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Is an eye pad needed in cases of corneal abrasion?

No, but exclude more serious trauma first

Although the transparent cornea acts primarily as a lens, it also shields the contents of the eye. Protection is provided by the corneal epithelium, which is supplied by a network of sensory nerves that cause extreme pain and immediate blepharospasm when stimulated. Injuries to the corneal epithelium have traditionally been treated with antibiotic ointment and an eye pad, but evidence has emerged that the eye pad may not only be ineffective but also retard healing.

Four types of lesions occur after corneal trauma: epithelial defects, epithelial and superficial stromal defects, deep stromal defects, and full thickness defects. Corneal abrasions affect only the epithelium and cause disablement for up to three days. Abrasions are usually due to accidents caused by such items as twigs, the uncontrolled pages of a newspaper, and unrestrained fingernails. Immediately there is agonising pain, watering, and photophobia, which are relieved by applying temporary pressure on the closed eye. Such injuries account for a tenth of new cases in some eye casualty units.¹ The history itself is enough to deduce the diagnosis, but examination is necessary to exclude foreign bodies, hyphaemas, and serious corneal lacerations.

Epithelial wounds heal primarily by the migration and proliferation of cells that slide in to repair the deficit. A recent study has shown that patients treated with antibiotic ointment and mydriatic drops alone showed significantly faster healing than those given an occlusive eye pad and bandage as well.² In fact, two fifths of patients had to remove their pads because of discomfort. The explanation is that a firm eye pad may produce an adverse corneal environment, applying pressure to the regenerating epithelium as well as reducing oxygenation. Similarly, after the removal of a corneal foreign body healing occurs almost always within 24 hours, and an eye pad seems to confer no extra benefit.³

On the other hand, double padding—padding both eyes—

has been reported to activate healing more rapidly than a single pad,⁴ although double padding has not been compared with no padding. Double padding probably works through reducing ocular movement. Also, porcine collagen shields—translucent and placed on the eyeball—reduce pain more quickly and are more comfortable than conventional eye patches and allow immediate visual recovery.⁵ They are, however, expensive and available only in hospital eye departments.

The evidence is that eye pads for corneal abrasions and foreign bodies serve no useful purpose and may even delay wound healing. These moderately benign and common conditions should therefore be treated with topical antibiotics and mydriatics alone. The antibiotic can be given as drops—for example, chloramphenicol, framycetin, fusidic acid, or neomycin sulphate—and a short acting mydriatic such as tropicamide will relieve discomfort, though it will also temporarily reduce accommodation. Such simple remedies can be given in general practitioners' surgeries, provided that care is taken to exclude other conditions that may masquerade as abrasions. These conditions, such as dendritic ulcers due to herpes simplex virus, are best identified by staining the cornea with fluorescein and examining it with a blue light source.⁶

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