Implant cards received by patients over time

operatively; the remainder achieved 0-45% success. Although certain patients were identified against their individual implanting centre, it seems that some implanting centres are better than others at forwarding implant cards to patients.

Comment

Present implant card schemes are falling well below acceptable standards. Nearly half of the patients sampled had not received an implant card 12 months postoperatively. Furthermore, patients who had not

received the implant card by six months postoperatively were unlikely ever to do so. It would be unfair, however, to blame valve manufacturers alone. Implanting hospitals may fail to send details to the manufacturer or the card to the patient.

We believe that the situation could easily be improved. Currently, UK cardiac centres send implant details to the heart valve registry. Authorising the registry to send the implant card to the patient would remove the manufacturer and clinician from the process. The manufacturer would receive anonymised implant information for postmarket surveillance and patients would receive their cards quickly. This centralised system would be cost effective, could be financed through a small charge per valve implanted, and would contribute to patient surveillance.

We are grateful to all staff involved with the UK heart valve registry for assimilating and maintaining the national database. All participating hospitals do so voluntarily (see *BMJ*'s website for a list of hospitals involved).

Contributors: M-BE designed the study and wrote the paper. She is also the guarantor. KMT is director of the UK heart valve registry and helped write the paper.

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Childhood deaths from acute appendicitis in England and Wales 1963-97: observational population based study

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The number of children under 15 years of age certified as dying of acute appendicitis each year in England and Wales decreased from the 1930s to the 1980s. Factors contributing to death have been analysed in audits in 1963-7 and 1980-4.^{1 2} We undertook an audit of children dying in 1993-7, compared these results with those of previous audits, examined hospital administrative statistics,³ and identified possible reasons for the fall in the number of deaths.

Methods and results

We used similar methods to previous audits to examine hospital and coroner's reports of all 12 childhood deaths in 1993-7.^{1 2} The median age of the children who died was 10.6 (range 3.0-14.2) years. Six children died at home or on arrival at hospital, and six died postoperatively in hospital from multiorgan failure (four in district general hospitals, two in children's

hospitals). Median duration of symptoms before hospital admission or death was 3 (2-6) days. Difficulty or delay in diagnosis was the main factor contributing to death in six cases.

The number of deaths from acute appendicitis in hospital fell from an annual average of 36.2 in 1963-7 to 1.8 in 1993-7. The case fatality rate in hospital has fallen from 1.06 to 0.16 per 1000 discharges with acute appendicitis, a fall of 85% (table). If children who were moribund on arrival at hospital are excluded the decrease is 97%. If the 1963-7 age specific death rates had applied to children admitted with acute appendicitis in 1993-7 the expected number of deaths would have been 50 rather than the nine recorded. Thus 41 of 172 (24%) fewer deaths in 1993-97 may be attributed to a fall in the hospital case fatality rate, the greatest improvement being in the youngest age group.

The number of children with a discharge diagnosis of "acute appendicitis" fell from an annual average of

Death rates per 1000 discharges (actual number of deaths) in hospital from acute appendicitis in England and Wales

Period	Age (years)			All
	0-4	5-9	10-14	
1963-7	6.5 (71)	0.96 (56)	0.53 (54)	1.06 (181)
1980-4	3.13 (8)	0.35 (8)	0.15 (9)	0.30 (25)
1993-7	0.44 (1)	0.12 (2)	0.15 (6)	0.16 (9)
Fall in death rate (%)				
1963-97	93	87	72	85

34 000 in 1963-7 to 11 500 in 1993-7; the discharge rate fell from 3117 to 1153 per million children (63% fall). The discharge rate for children with "operations on the appendix" decreased by 60%, and the rate for children with a discharge diagnosis of "abdominal pain" increased by 88%. The population of children aged 0-14 years decreased by 8.5%.

Comment

Three quarters of the dramatic fall in the number of children dying of acute appendicitis during the past 30 years is due to a decrease in the incidence of appendicitis in a slightly smaller child population. A quarter of the fall is due to a marked decline in the hospital case fatality rate, probably reflecting improved medical care. In the 1960s the main factors contributing to death were inadequate fluid replacement, anaesthetic complications, hyperpyrexia, convulsions, sepsis, and difficulty or delay in diagnosis. Difficulty or delay in diagnosis is now the main factor contributing to the small number of deaths.

The recorded decline in discharges for acute appendicitis has been noted in other studies, and the parallel rise in discharges for abdominal pain suggests

that some of this fall is due to improved diagnosis. The combined impact of computer aided diagnosis, clinical scoring systems, ultrasonography, laparoscopy, and cross sectional imaging techniques remains uncertain. Clinical assessment and "active observation" still have a vital role in the diagnosis of acute appendicitis.⁴

The reason for the declining incidence of acute appendicitis is unknown. It has been attributed to improved hygiene and changing patterns of childhood infection resulting in less lymphoid hyperplasia in the gut.⁵ It is intriguing that such a dramatic reduction in the number of cases of a serious and worrying illness has come about for reasons that are not clear and without any national strategy.

We thank the consultants and coroners who kindly responded to our requests for information and Professor Richard Thomson for helpful advice.

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A call for help

Many of us are brought up from an early age with the story of the good Samaritan. In the original story the Samaritan volunteered his services. Doctors, however, are expected by society to volunteer to come to the aid of people in need, even when they are off duty. I suspect that many worry about this prospect as much as I do.

A few months ago, I was relaxing in the coffee lounge of a large hotel after an anniversary dinner with my wife. The agreeable postprandial peace was suddenly interrupted by a loud, high pitched scream coming from the hotel lobby. Shortly afterwards bedlam began. A rather flustered, severe looking, middle aged woman began rushing round frantically asking for help. "Call the police, call an ambulance," she shouted.

I got up, rather reluctantly, I admit, and went over to investigate. The first thing that surprised me was the number of onlookers that had gathered, perhaps up to 20 people. Most of them seemed to be hotel guests with some anxious looking staff members mixed in. Naturally, none of them seemed to be doing anything useful, just looking a bit awkward and avoiding eye contact with each other.

I made my way through the crowd, trying not to be too conspicuous, until I saw the cause of the commotion, a young woman lying on the floor. An initial glance showed she wasn't moving, and she seemed to be unconscious. I also noticed a large bump on her forehead. Action was needed and fast, I thought. I took control, pushed my way through to her, muttered

"Airway, breathing, and circulation" to myself, and knelt down beside her.

Suddenly, before I could perform any heroics, I was grabbed forcibly from behind. I looked round to see who was interrupting my lifesaving work. The middle aged woman who had been asking for help was looking even more flustered and severe than before. "What are you doing, what are you doing?" she shouted at me. I felt the burden of the gaze of the crowd, which had now swollen to about 30 people.

In a need to justify my presence an inspirational line came to me: "Don't worry, dear. I'm a doctor."

There was an unnerving pause, and her face changed, she grinned, leaned toward me, and whispered in my ear, "Don't worry, doctor. It's a murder mystery party."

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We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.