PostScript

LETTER

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National Service Framework fails to address the decision time

The benefits of early thrombolysis in acute myocardial infarction are well known.[1] In March 2000 the National Service Framework for coronary heart disease established a target of 60 minutes between the patient's call for help and the delivery of thrombolysis.[2] Emphasis is placed upon improved ambulance response and more efficient delivery of in hospital or prehospital thrombolysis, but hardly any attention is paid to the "decision time": the minutes that elapse between symptom onset and a call for professional help.

We routinely audit all patients thrombolysed in our inner city emergency department. Times of pain onset and call for help are recorded when available. Between February 2000 and January 2001 complete data are available for 94 of the 127 patients thrombolysed. Sixty two (66%) of these patients had experienced symptoms for more than half an hour before calling for help. The median decision time was 60 minutes. Twenty per cent of patients called their general practitioner rather than an ambulance.

From June 2001 to June 2002 we also recorded whether each patient thrombolysed was known to have previous coronary heart disease. Complete data on 108 of the 123 patients thrombolysed revealed that 38 had known and 70 unknown coronary heart disease. The median decision times were 77 and 60 minutes respectively.

Our figures strongly support the view that overall "pain to needle" times are greatly undermined by prolonged decision times. For whatever reason, many patients remain reluctant to seek assistance, and comparison with previous audit suggests that very little has changed since 1993.[3] It also seems that patients with known coronary heart disease are no more likely to seek early professional help.

We believe that there is a need for greater emphasis on patient education within the National Service Framework. Improvements in the "pain to needle" time, and thereby patient outcomes, are now most likely to be achieved through a reduction in decision times, but the best approach to this problem remains unclear. Previous media campaigns undertaken in Europe have led to significant reductions in the decision time, though the cost of this has often been an increase in the number of emergency department chest pain attendances, many of whom do not have significant cardiac disease.[4] We suggest that an effective and contemporary public education strategy is urgently required, and that the effect of this intervention be evaluated as fully as possible. In the meantime we wish to reiterate the simple recommendation made by the National Service Framework and British Heart Foundation: patients with ischaemic heart disease should call an emergency ambulance if their angina is unrelieved after 15 minutes. In addition, any member of the public experiencing symptoms suggestive of myocardial infarction should call the ambulance service and not their general practitioner.

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1 **Anonymous**. Indications for fibrinolytic therapy in suspected acute myocardial infarction: collaborative overview of early mortality and major morbidity results from all randomised trials of more than 1000 patients. Fibrinolytic Therapy Trialists' (FTT) Collaborative Group. *Lancet* 1994;**343**:311–22.
2 **Department of Health**. *National Service Framework for coronary Heart disease.* London: HMSO, 2000.
3 **Birkhead JS**. Trends in the provision of thrombolytic treatment between 1993 and 1997. Myocardial Infarction Audit Group. *Heart* 1999;**82**:438–42.
4 **Blohm MB**, Hartford M, Karlson BW, *et al*. An evaluation of the results of media and educational campaigns designed to shorten the time taken by patients with acute myocardial infarction to decide to go to hospital. *Heart* 1996;**76**:430–4.

BOOK REVIEW

Anaesthesia at the district hospital, 2nd edn

M B Dobson. ($31.50). WHO Publications, 2000. ISBN 9-241-54527-5

The past is another country, but a different country can also be another today, especially when that country is in the developing world. This book is directed at doctors providing anaesthesia in the small district hospitals of such countries, where equipment, drugs, and specialist help are all in limited supply.

The watchwords throughout are safety and the use of a comparatively small number of techniques that will permit safe anaesthesia for most situations. But the author is not afraid to emphasise the importance of basing techniques on a sound knowledge of the underlying science and of subjecting practice to some form of audit. These general principles are not a bad start for any anaesthetist or, indeed, any doctor in this country.

It is for these reasons, along with the clarity of the text and the excellent illustrations, that I recommend the book to doctors on the threshold of careers in anaesthesia and A&E medicine. The aspiring anaesthetist will find the whole book of interest and a useful framework for the future. The draw-over technique may never be seen in this country but it should provide thought about why anaesthetic machines developed as they did, what their advantages are, and what are their limitations.

Perhaps only a smaller section of the book is of direct interest to the A&E doctor. The chapter on fundamental techniques gives a lucid account of airway management and intubation. Some of the anaesthetic methods, in particular the use of ketamine, will be useful to a future member of any retrieval team.

The section on management of cardiac arrest would have been strengthened by the incorporation of recent ERC guidelines. Undoubtedly this section focuses on arrests likely to occur under anaesthesia, but there is too much emphasis on pupils and too little on the defibrillator.

I found the book an excellent introduction to anaesthesia in difficult environments. It puts some NHS problems into perspective and thereby broadens rather than restricts our viewpoint. They know little of anaesthesia who only of modern anaesthesia know.

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CORRECTION

An error occurred in this paper by Dr F E Lecky and others (2002;**19**:520–3). In the key to figure 2, the triangles indicate the consultant line (not the circles), the squares indicate the middle grade line (not the triangles), and the circles indicate the SHO line (not the squares).

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Emerg Med J 2003 20: 208
doi: 10.1136/emj.20.2.208