

LETTERS

Contribution to national acute injury and intensive care audit databases in England and Wales

Recently attention has been turned to trauma care provision,^{1,2} and the 2010 report on 'Major Trauma Care in England' emphasises the lack of progress in trauma care in the UK.³ National audit databases collect information on patient care in many areas of healthcare in England and Wales, providing important epidemiological, treatment processes and clinical outcome information. We investigated the contribution of trauma-receiving emergency departments (EDs) to the Trauma Audit and Research Network (TARN) in 2009. These data were compared with data from the Intensive Care National Audit and Research Centre (ICNARC), the Paediatric Intensive Care Audit Network (PICANet) and the International Burn Injury Database (iBID). The nationwide contribution was less than complete for TARN (115/214, 54%) and ICNARC (181/214, 85%). Different strategic health authorities (SHAs) also showed wide variation; highest TARN contributors were North West (27/31, 87%), and East Midlands (10/12, 83%), lowest were London (10/32, 31%) and South East (7/18, 39%). The highest ICNARC contributor was East Midlands (12/12, 100%), lowest was London (23/35, 66%). Eight out of 11 SHAs had $\geq 90\%$ ICNARC contribution. Contribution to PICANet and iBID was 25/26 units (96%) and 25/31 (81%), respectively.

These data demonstrate that the specialised services of intensive and burn care have higher participation in national audits than EDs. This might be due to their smaller size and relatively lower rate of staff turnover and high staff to patient ratios, making data collection and submission more manageable. Their degree of specialisation may also encourage a culture of audit. However, there is no reason that trauma-receiving EDs cannot achieve greater TARN coverage, and it is important to note that TARN contribution has increased from 31% in 2008 to 54% in 2009. Major Trauma Care in England recommends that EDs contribute to TARN and SHAs use TARN data to evaluate trust performance.³ These umbrella organisations commission specialised services and might offer a route for encouragement of participation in national audit projects.

It is most encouraging that England and Wales are leading the way in acute injury and intensive care audit. TARN is now being taken up by hospitals throughout Europe and a European working group has been created,⁴ and there are moves to introduce iBID in several countries. The near complete national audit coverage for ICNARC, iBID and PICANet described in this letter demonstrates an almost unique global position: the national

system in the UK, in which all acute hospitals are linked through the NHS, enables comparable audit on a truly complete national scale. This position is advantageous for audit and ultimately improved patient care.

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Diagnosis of acute vertigo in the emergency department

Acute vertigo accounts for 12% of neurological presentations to emergency departments.¹ Over 12 months, the neuro-otologists' diagnoses from 90 referrals seen in our emergency department were benign paroxysmal positional vertigo (BPPV) 31, vestibular neuritis 14, history of vestibulopathy with no diagnosis (normal assessment) 14, vestibular migraine 12, anxiety/panic disorder 11, stroke 4, presyncope 4. BPPV was the most common diagnosis and this is important because BPPV is easily diagnosed and treated with simple manoeuvres (figure 1). In textbooks, BPPV appears as the main cause of episodic/recurrent vertigo²—not acute vertigo. The typical history is intense but brief (<1 min) vertigo on 'looking up', getting up from, lying down on or turning over in bed. However, the first episode of BPPV is terrifying and some patients report continuous vertigo. In conclusion, the Hallpike positional manoeuvre must be performed in all patients with new vertigo.

Videos of the manoeuvres are available in the following websites: <http://www.bmj.com/content/339/bmj.b3493.full>; <http://www.>

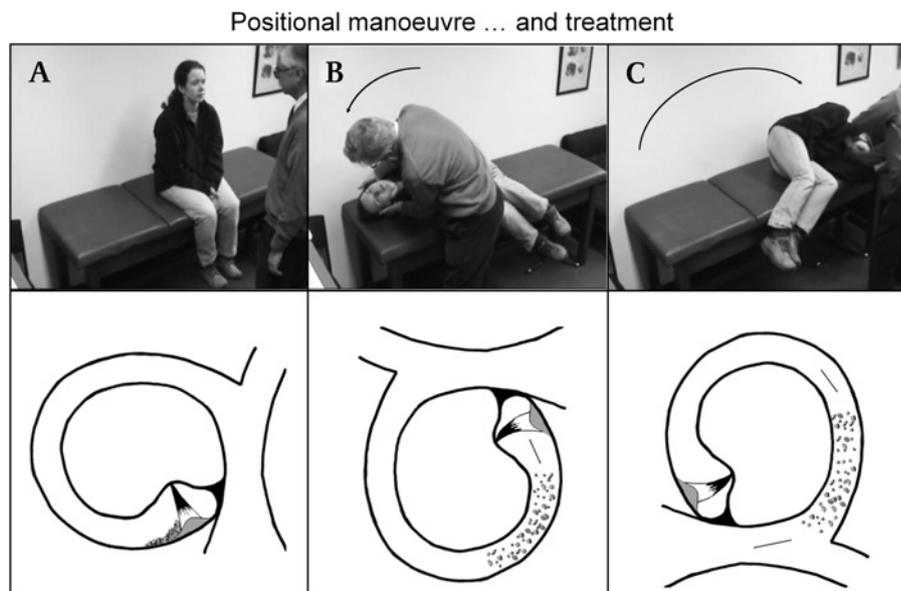


Figure 1 The photographs show a modified Hallpike manoeuvre (A and B) for right sided benign paroxysmal positional vertigo. If in the right ear down position (B) the patient has typical vertigo and torsional nystagmus, then, after 20–30 s, proceed to treatment with the Semont manoeuvre (C) by rapidly swinging to the opposite end of the couch. Note that in (A) the patient is right ear down for diagnosis (ie, nose up) but in (C) she should 'land' nose down (remember: nose up for diagnosis but down for treatment). Overweight or elderly patients may require an assistant helping from behind as these manoeuvres should be carried out quickly. The cartoons below show the canaliths or crystals causing positional vertigo (B) and how they exit during treatment (C). Other 'repositioning' treatments, such as the Epley manoeuvre (not shown here), are similarly effective; the odds in favour of treatment are approximately 30.³