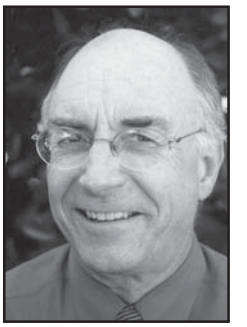
Editorial



Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

Medical emergencies

Reflecting on one's past experiences is a powerful trigger for learning. I was going to write 'learning from one's mistakes' but times change and the situations that we were confronted with 20 or 30 or even 10 years ago are quite different from what they are today. I believe that it is more helpful to use these past experiences as triggers and consider how, if we were confronted with the same situation today, we would manage, given our current knowledge and resources. We usually do this in the privacy of our own minds, but sharing these experiences with our peers not only helps with our own learning but also triggers learning experiences for our colleagues.

So, given the theme for this issue of the journal, I have been reflecting on medical emergencies that I have been involved with as a general practitioner.

The first that stands out is a young woman who presented postpartum with a fever and a purpuric rash more than 30 years ago. She was admitted to the small rural hospital in which I was the medical officer. There was not much doubt about the diagnosis of meningococcal septicaemia. She developed disseminated intravascular coagulation and we tried our best to stabilise her. A few days later she deteriorated and we managed to transport her by flying boat to a base hospital where she died two days after admission. Today I would have transported her immediately after giving antibiotics, although I cannot predict whether this would have altered the outcome.

A few years later, in a different town, I was called to see a 10-month-old baby who had had a cold for a day or two and then developed an unusual rash. I drove straight to the child's home, saw the petechiae on the skin of a floppy baby, put Mum and the baby in my car and drove the 10 minutes to hospital where the baby died in Casualty within half an hour. Perhaps I would now give penicillin before transporting, although I suspect that it would not have helped this baby. These experiences are always in my mind when I see an acutely ill patient with a rash.

Then there was the 40-year-old Maori man who came to see me with a sore backside. He had an early perianal abscess. Thirty years ago I had been taught that these should not be treated with antibiotics but allowed to become fluctuant and then opened and drained. We were two hours' drive from the nearest hospital so I sent him home with analgesics and asked him to come back to the clinic in a couple of days. Sure enough, two days later I spotted him sitting in the waiting room with the other patients who had turned up on the day. He didn't look well and I called him in to find that he had crepitus of his lower abdomen extending down to his scrotum and perianal area. I hadn't seen Fournier's gangrene before and I haven't seen it since but I was in no doubt that he needed to be in hospital. We got a taxi to take him half way to meet an ambulance coming up from the hospital 100 miles away (it was a long time ago). He had extensive surgical debridement but survived. I am sure that today I would give antibiotics immediately.

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Over the years I have attended numerous car crashes and bush accidents. At most of these my presence has probably not altered the outcome for the patient, but I do remember a truck driver who was trapped by his legs and bleeding profusely. We stopped his bleeding, got a couple of IV lines into him and poured in volume expanders while he was being cut out. He lost his legs but he did survive. My most useful function in most of these situations has been to administer adequate pain relief. I have found that titrated morphine is a very useful drug.

I suspect that most GPs will share my experience of being disappointed with the outcome of out of hospital resuscitation for cardiac arrest. We usually arrive too late, defibrillation is delayed, we go through the motions but the outcome is inevitable. However, there are exceptions. I was once called to a 14-year-old boy who had collapsed while sniffing a fire extinguisher. He was unconscious and pulseless. We did not have a defibrillator but a monitor showed that he was in VF. After about 15 minutes of chest compressions and oxygenation he developed sinus rhythm and after a few days in hospital recovered completely. I am not sure if he went back to sniffing solvents. On another occasion a patient arrived at my practice with epigastric discomfort. My practice nurse thought it prudent to run off an ECG and while she was doing this the man arrested. He was resuscitated successfully without the benefit of a defibrillator. He later came back to see me and asked if he could have a look at the picture in our treatment room showing a long line of angels! There was no picture. We now have a defibrillator in our medical centre.

There are other emergencies that have been important learning experiences for me. I recall trying unsuccessfully to intubate a teenage girl with status asthmaticus. She did not survive. I saw a young man with a tension pneumothorax but delayed putting a needle into his chest. He did survive. I have missed a SUFE but I have not missed a testicular torsion, although I may have unnecessarily sent a few young lads to hospital with epididymo-orchitis. My colleagues recently saw a young woman who developed a severe headache after a bout of coughing. She was admitted to hospital but died a few days later from a vertebral artery dissection. We spent hours discussing how her death might have been avoided.

Perhaps the most distressing emergencies for me have been unforeseen obstetric complications, although I no longer have these to worry about, and SIDS. I haven't been called to a sudden infant death for several years but, in the past 30 years, I have attended about 10. They have always been emotionally draining for me, as I have had difficulty coping with the grief and guilt of the parents. This was never helped by having to call in the police due to my inability to issue a death certificate.

In this issue both the theme papers and the CME section deal with some aspects of emergency care in general practice. These are diverse; road trauma, new resuscitation guidelines, a predicted avian flu epidemic, anaphylaxis and potentially serious causes to be in the back of our minds when dealing with certain acute presentations. Our hope is that these will encourage readers to consider how well prepared we are for emergencies, some of which we see frequently and some only rarely.