LETTERS TO THE EDITOR

MANAGEMENT OF SUCKING CHEST WOUNDS
From Major M L Carter, RAMC
Sir, Following the letters from Sgt Lawrence and Col Haywood, I would like to draw to their attention the method advised by the Advanced Trauma Life Support Course. This is to use, as at present, the package from the field dressing, but secured only on three sides. It, therefore, functions as its own flapvalve. This is cheap (free), light, small, already carried which can be applied as easily as is current practice.

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B A LAWRENCE

MANAGEMENT OF SUCKING CHEST WOUNDS
From SSgt B A Lawrence, RAMC
Sir, May I thank Colonel Haywood for his constructive comments regarding the use of the “Portex Resusiade” in the management of sucking chest wounds (Vol 135 No. 2 June 1989).

The following comments may alleviate his concern over some areas of the proposed procedure:

a) Colonel Haywood rightly expresses caution with regard to the blockage of the valve by blood. This is also a known problem with the Heimlich valve when used in the field and I believe we can be no less optimistic with the use of the “Resusiade” than the “Heimlich”.

b) Concern was also voiced regarding the risk that the device could be applied the wrong way round, either at night or in the heat of battle, or both. This is very understandable, but I firmly believe that two aspects preclude this happening:

1) Firstly, you will recall I suggested that a flexible adhesive backing may be applied to the surface which came into contact with the wound. By touch alone, the person applying the device could easily recognise that it is being affixed to the casualty the correct way round.

2) The “Bite-Block”, which protrudes some 0.5 cms above the upper surface of the device, would again by touch alone be a further foolproof indication that it is being applied correctly.

Thank you for allowing me this opportunity to reply to Colonel Haywood.

I am etc
B A LAWRENCE

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Please note: Further correspondence on this matter should be addressed through staff channels to the RAMC Technical Development Team.

WHATEVER HAPPENED TO AMD RESEARCH PROJECT 247?
From Colonel D E Bradford, L/RAMC
Sir, Three years later (JRAMC (1987), 133, 65) and a chance to return to our non-smoking hospital. It is a delight to state that things seemed to have improved.

There is now very little public smoking inside the hospital although there are still badly sited “designated areas” where patients are often aware of smoke or smell billowing out into a waiting room or a clinic area.

One problem we still have is the collection of young soldiers just outside the main entrance having a quick puff between investigations, but the general feeling is that smoking is a less obvious problem.

In 1987 a rough calculation showed that almost twenty percent of staff did not wish to stop smoking. A rapid poll now shows a smoking population of 42% and even there is an increase in the number of smokers since 1987 then some at least are doing it out of sight.

We now need to make the bold move of a ban on smoking at work for all AMS Staff.

I am etc
D E BRADFORD

MITRAL VALVE PROLAPSE
From Colonel P Lynch, L/RAMC
Sir, Lt Col Johnston1 has identified an area of muddled thinking, adopted a contrary pose and used diligence and erudition to fight his way through. Nothing wrong with that, but he has rather missed the point. Thin, anxious, young soldiers often present with stabbing left mammary pain, palpitations and dizzy spells and are found to have all manner of cardiological epiphenomena. Now, whether you call this Da Costa’s syndrome or Soldier’s Heart or Mitral Valve Prolapse syndrome does not matter terribly provided you do not miss the diagnosis altogether and call it, for want of better, subendocardial infarction. This is not as far fetched as it might seem. Consider the pain and the fainting came on during a basic fitness test and on
admission to St Civilian's our young soldier had the Wenckebach phenomenon, elevated enzymes and T-wave inversion across the anterior chest leads. What price then the young man's career, even if the angiogram is normal? That is not to say that it is not a subendocardial MI, merely that the benign Da Costa's syndrome is much more likely. The civilian doctor is likely to give no weight whatever to what is, for us, an everyday diagnosis presenting, I may say, typically. Army doctors must always bear in mind that our population is not that of the textbooks nor is our differential diagnosis of chest pain. That being said the name mitral valve prolapse takes the eye off the presenting complaint and highlights an irrelevance. In that, at least, I agree with Lt Col Johnston.

P LYNCH

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REFERENCE

Author's reply

Sir, I reviewed the literature on an enigmatic condition in an attempt to put it into a proper perspective; I included some historical material to show the military importance of correct diagnosis. I am sorry that Colonel Lynch feels I have missed 'the point' which seems to be that Mitral Valve Prolapse is a better diagnosis in soldiers with atypical chest pain than Myocardial Infarction. I am afraid that he has missed at least one of the 'points' I was trying to make: Mitral Valve Prolapse does not cause chest pain. I agree with him of course that diagnosing heart disease in people (of whatever age) who have no disease is bad medicine.

J H JOHNSTON

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DUNKIRK VETERANS

The Royal College of Nursing History of Nursing Group are preparing an exhibition to mark the 50th anniversary of the Dunkirk Operation this year. It is intended to tell the story of Dunkirk from the viewpoint of RAMC and QARANC personnel. Anyone who took part in the operation or who was left behind to look after wounded POWs, is invited to contribute diaries, letters and photographs and should contact Miss Angela Gould, Chairman History of Nursing Group, Royal College of Nursing, 20 Cavendish Square, LONDON W1M 0AB.