

Crisis in emergency medicine

Sir,

Having read your editorial "Emergency medicine in times of crisis"¹, I can only congratulate you on the article, which I consider a qualitative leap in providing new ideas from an eminently scientific forum. I would like to add some further considerations to the editorial.

Classically, a specialty is considered to exist when it fulfils certain criteria²: it must have its own body of specialised knowledge, a demand for care, professionals specifically engaged in such work, and literature and publications pertinent to its own field of knowledge. The first point is undeniable. There is a body of specialised knowledge, which is undoubtedly transverse as is in other specialties. This is reflected in historical documents presented by the Spanish Society of Emergency Medicine and Emergencies (SEMES)³ to the Ministry of Health, or in documents already collected at the European level and endorsed by the European Union of Medical Specialists (UEMS), such as the recent "European curriculum in Emergency Medicine"⁴. Needless to say, in countries where the Specialty of Critical Care and Emergency Medicine has existed for years, such as USA, Great Britain and Ireland to name a few, there is no question about this. With regard to the demand for care, simply citing the figure of 30 million annual visits attended by emergency services in Spanish hospitals is sufficient to settle any controversy in that regard. Not to mention all the Emergency Medicine professionals. There are more than 10,000 in Spain, more than half of whom are affiliated to the scientific society SEMES, which is ranked third in Spain in terms of membership numbers. It is therefore clear that SEMES has the most intrinsically authoritative role as the voice of Emergency Medicine in this country. And finally, its publications (both books and journals) are well known and referenced, with this journal being an example.

Despite all this, surprisingly, there remains a viewpoint that questions the specialty of Emergency Medicine, expressed by those who do not represent this group⁵ because they do not know (ill-informed or not wishing to know) and do not practice emergency medicine. Furthermore,

such a position flaunts the decisions already taken by Parliament itself⁶ and blindly insists on refusing to accept the specialty of emergency medicine.

There are many opinions, but authorized opinions are few and far between. And these few should be those of the experts in the field, those belonging to the group whose daily life is the practice of emergency medicine and active research. As a good investigator, I believe, as a practicing professional in an emergency department and as a director of the Society in Catalonia legitimately representing emergency physicians, I think your opinion is "truly authoritative" and is shared practically in its entirety by many of us. To be able to distinguish these opinions from mere sophism is one of the keys to reading and appreciating a good editorial or scientific article⁷. Once again, my sincere congratulations on your excellent editorial.

It is the duty of all democratic governments to turn successful parliamentary initiatives into law, and parliaments are the voice of the population that supports them. Pink Floyd, in 1975 (the same year that Supertramp brought out *Crisis*, what crisis? to which you referred in your editorial) brought out their album *Wish you were here*, and, like Supertramp, things did not work out badly for them either. I know that all of us Emergency physician "will be here" when the Royal Decree⁸ is published (soon) to create the Specialty of Critical and Emergency Medicine in Spain. Let there be no doubt - there will be no crisis.

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A psychotherapeutic editorial

Sir,

Your editorial published last August¹ generated different sensations in me that I would like to convey, hoping they will be of interest. You have made a great effort to convince us that there is no crisis in Emergency Medicine, with no less than 6 arguments employed in the attempt. When so many psychotherapeutic arguments are needed, things are not going well for us and I am not persuaded otherwise.

In the first part of the Editorial you correctly highlight the high degree of burnout amongst Emergency physicians; this is a key element in the current crisis - I would say the most important - although not exclusive to the emergency services, and there is no prospect of any short-term solution.

Emergencies departments, at least those in hospitals, lack sufficient autonomy to organize themselves: they do not control their own entrance door (patient flow is spontaneous or regulated by the health system) or any of the important major exits (hospital admission). Furthermore, if the rest of the hospital turns their back on the emergency department, the loop is closed and the sensation of being swamped is almost continuous.

Your editorial only addresses emergencies from the physician point of view and makes no mention of other professionals working in "Emergency Medicine", people who will also read the journal EMERGENCIAS and are members of the Spanish Society of Emergency Medicine (SEMES); they too are affected by the same crisis and perhaps worse burnout. I do not understand this apparent oversight.

After going over your 6 arguments, I am not encouraged. The notion that vocation to become an emergency physician is increasing is an unproven hypothesis, to which TV series may be contributing. But after the initial enthusiasm comes the daily routine, no doubt less monotonous but harder than other specialties, and that requires a stimulus, recognition and compensation which are usually lacking. The idea that we are all

totally committed to the specialty is simply not evident judging from the recent elections for the presidency of SEMES. But I do agree that emergency medicine is effective and efficient, always present, that the group of professionals is very large and generally well prepared and that users know that the emergency department is where they can go for rapid diagnosis and resolution of their health problem. Indeed, overcrowding of emergency departments is proof of their success and one of the reasons for the crisis.

Very probably my opinion is more a single-centre reflection than a global vision of Spanish emergency medicine. I do not wish my words to be interpreted as defeatist or as announcing the big bang, but rather as the opinion of one who has spent 33 years of professional life in an emergency department and who does not share the idyllic view of the Editor of EMERGENCIAS.

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Editor's reply

I greatly appreciate the letters of Dr. Vazquez Lima and Dr. Nogué Xarau regarding my editorial "Medicine in times of crisis", not only for the personal interest they show but also because they publicly express comments verbally communicated to me by certain readers of EMERGENCIAS.

Dr. Vazquez Lima lists the conditions that a particular field of medical knowledge must meet to be recognized as a specialty, all of which are amply met by Critical Care and Emergency Medicine. Perhaps because of this, despite all the solid arguments (shared by many other physician and non-physician medical professionals analyzing the situation impartially²⁻⁴), the author denounces the negative pressure and discourse from groups with vested interests who do not want our specialty to be legally enacted. We must avoid these siren voices that seek to distract and to overturn our project now approaching fruition. Like Ulysses, we should cover our ears and not heed them.

The lines written by Dr. Nogué Xarau express scepticism about the picture my editorial paints. Some of the arguments are undeniable, such as

the degree of professional burnout^{5,6} or the lack of autonomy of many emergency departments, which do not control patient flow into and out of the Emergency Department^{7,8}.

However, the author only calls into question two of the six arguments on which I based the editorial opinion that Emergency Medicine is not in crisis: the existence of vocation and the internal commitment of our Spanish Society of Emergency Medicine (SEMES). It is true that the existence of vocation to choose Emergency Medicine when it becomes available as a specialty is an unproven hypothesis. However, a survey of students from Catalan medical schools shows that, of the 7 options (Internal Medicine, Family and Community Medicine, Cardiology, Intensive Care Medicine, Traumatology and Orthopedics, General and Digestive Tract Surgery, and Emergency Medicine), Emergency Medicine was the third most selected option (Dr. Blanca Coll Vinent, personal communication). This supports the view of those of us in contact with medical students in training.

Furthermore, I do not think the electoral disputes question the degree of commitment within SEMES when discussing something as fundamental as the creation of the specialty. Elections are always periods of reflection, internal debate and formulating proposals for the achievement of objectives that are common to all members.

My editorial did not intend to set aside other SEMES professionals. On the contrary, it was written as an analysis of the situation of Emergency Medicine, as a medical specialty, and as a reflection on the situation for all the professionals forming part of SEMES. The journal EMERGENCIAS is open to all, and in brief the editorial will discuss the concerns of particular groups of nurses and medical transport technicians.

And finally, a comment about the alleged psychotherapeutic properties or intentions of my editorial: everybody needs psychotherapy sometimes in life and if my article has had that effect on some readers, albeit unintentional, then so be it.

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Oscar MIRÓ

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Acute peripheral arterial occlusion in an upper limb

Sir,

Acute peripheral arterial occlusion of the upper limb in subjects who are not intravenous drug addicts is a rare entity. It is characterized by interruption of blood flow to certain areas of the organism following the sudden occlusion of the blood supply artery, resulting in hypoperfusion, hypoxia and necrosis if circulation is not restored. The causes may be varied: embolism, thrombosis, trauma, or aneurysm.

An 82 year-old woman consulted our primary care emergency service for paleness and right hand coldness of 2-3 hours evolution, without pain or alteration of strength or sensation. Altered colour and coldness of the right forearm were observed. Vascular examination revealed the presence of right brachial pulse (arrhythmic) and absence of right radial pulse. Electrocardiography showed hemiblock of the anterior subdivision, the axis at -40° and atrial fibrillation not previously known by the patient. Acute arterial occlusion of embolic origin was suspected (Table 1) on finding as underlying pathological heart rhythm disorder. This resulted in referral to hospital for diagnosis supported by a Doppler study and cardiovascular evaluation by a specialist¹. Doppler usually provides sufficient information to facilitate a diagnosis of the lesion, and allows the measurement of vessels and speed of blood flow, which establishes the diagnosis of peripheral vascular disease. In this case, there was no distal flow; transthoracic echocardiography showed left ventricular hypertrophy and bi-atrial dilatation. Evolution showed improvement of the limb, although no radial or ulnar pulse, but with monophasic flow detectable by Doppler. The cardiovascular surgeon decided on discharge with drug treatment (anticoagulant and digoxin).

About 70-80% of arterial embolism is located in the large vessels of the limbs, five-fold more often in the lower limbs. What was striking in our case was the decision not to perform invasive treatment, despite the fact that in reviews of the literature⁴ the treatment of choice is surgical inter-

Table 1. Differential diagnosis between acute ischemic syndrome (AIS) and deep vein thrombosis (DVT)

	AIS	DVT
Pain	+++	++
Sensitivity	According to location	No change
Temperature	Important decrease	No change or slight elevation
Edema	No	Yes
Colour	Paleness/cyanosis	Cyanosis
Pulse	Non-detectable	Present
Superficial venous reflection	Decreased	Conserved or increased

vention (thrombectomy or embolectomy with Fogarty balloon catheter, etc.).

All these options were offered to our patient who finally opted for medical treatment with good outcome. Acute ischemia of a limb⁵ is still associated with high morbidity, risk of loss of limb and resulting physical, mental and social consequences; hence the importance of early diagnosis and treatment.

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Complication with a port-a-cath device

Sir,

The implantation of a permanent subcutaneous reservoir (port-a-cath) is the alternative to central venous path for patients who need long-term venous access: it provides fast, easy to find, secure and durable access¹. Complications in patients with these systems are rare^{2,3}.

A 73-year-old man with a history of hypertension, deep vein thrombosis and stage IV gastric carcinoma receiving chemotherapy through a port-a-cath system, consulted the emergency department for sharp discomfort in

the region of the reservoir, of ten days evolution. Physical examination showed no swelling, redness, heat, or evidence of infection in the region of the reservoir. Posteroanterior chest X-ray with and without contrast showed rupture of the proximal catheter reservoir, with contrast of the vein passing into the distal fragment (Figures 1 and 2). The patient was admitted to the vascular surgery department where the port-a-cath reservoir was removed without complications.

The port-a-cath system consists of a reservoir or titanium portal placed under the patient's skin, a radiopaque silicone or polyurethane catheter placed in the venous stream (the route most frequently used is the right subclavian vein)¹ and a catheter connecting the two structures. A port-a-cath can be placed by surgical means or by interventional radiology techniques. It is used for the administration of chemotherapy, blood or derivatives, antibiotics, parenteral nutrition and to obtain blood samples⁴. Possible complications include infection, blood clotting, catheter migration, occlusion, pneumothorax and vascular erosion⁵.

Spontaneous rupture of the catheter is a rare complication. Symptoms include palpitations or chest discomfort, but such rupture may also be asymptomatic⁴. The etiology is unclear, although the most important is considered to be incorrect placement. Other causes include defective catheter material or alterations in the mechanical properties of the catheter material, probably due to the effect of substances administered⁴. Diagnosis is based on chest X-ray imaging, which may



Figure 1. Posteroanterior chest X-ray showing rupture of the proximal junction of the catheter and the port-a-cath.



Figure 2.

sometimes require contrast enhancement. Treatment involves removal of the catheter and its

fragment by surgical or interventional radiology techniques.

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