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Reply

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EDITOR:

The authors of the Working Party on Emergency Medicine of the European Board of Anaesthesiology (European Union of Medical Specialists, EUMS/UEMS) want to thank Dr Raed and colleagues for their correspondence. However, we are afraid that Dr Raed and colleagues have misunderstood the intention of our paper. Our paper, in fact, describes the part of the core curriculum in Anaesthesiology dedicated to Emergency Medicine, as is desirable and as is required for any resident who is trained as an Anaesthesiologist in Europe.

In contrast to what Dr Raed and colleagues suggest, our paper does in no way promote exclusivity. Emergency Medicine in Europe is diverse, has different contents and different positions in different countries in association with varying organizations of medical care, varying geography and varying resources. With the exception of nine European Countries, Emergency Medicine is not an independent speciality in most European Member States.

The European Directive on recognition of professional qualifications (Directive 2005/36/CE of the European Parliament) does not identify Emergency Medicine as a primary medical speciality. The

European Union requires that, to become a speciality it must be recognized in at least two-fifths of the Member States and at the same time, by a particular majority (a weighted vote that is determined by the population of each country and other factors and giving what is called a 'qualified majority') in a committee on Qualification of the European Commission (not only for medical professions but generally also for all protected professions). Furthermore, to create a Specialist Section for Emergency Medicine within the UEMS, Emergency Medicine has to be recognized as an independent speciality by more than one-third of the EU Member States and must be registered in the official Journal of the European Commission (Medical Directives). All these requirements for a primary medical speciality are not fulfilled for Emergency Medicine.

The European Board of Anaesthesiology (and not the European Society of Anaesthesiology, which unfortunately was misquoted in the correspondence) has no ambition to be involved in the crusade of the European Society of Emergency Medicine to have Emergency Medicine recognized as a separate medical speciality.

Emergency Medicine has many definitions in many regions and countries in Europe. In our opinion it would definitely be preferable first to agree on the definitions of Emergency Medicine in Europe and then to agree on the competencies that are required to achieve high-quality care in Emergency Medicine throughout Europe. It is also important to identify

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general quality indicators for Emergency Medicine, applicable to all countries and health care systems.

It then remains to be seen whether the institution of Emergency Medicine as a separate medical specialty is the way to go to achieve the aforementioned goals. This may be the case for some countries in Europe, but not for others, depending on many factors.

Like for Intensive Care Medicine, the multidisciplinary input from various specialties is considered essential to achieve high-quality care in Emergency Medicine. This multidisciplinary input threatens to be lost by the institution of a separate specialty. We do agree with the authors of the correspondence: let us not forget the history of medicine. Too widespread a specialization in medicine has created barriers in the past, which have not served well for the quality of care for our patients. However, mutual stimulation, mutual respect, communication and cooperation are characteristics which we do have!

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A benign cause for a unilateral dilated pupil in a critical care patient

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EDITOR:

'Anisocoria' (a unilateral dilated pupil) in critical care patients is a point of concern, which warrants a thorough examination and often, also, costly investigations to rule out a serious cause. We however, encountered a patient in our intensive therapy unit who had a more benign reason.

Case report

A 38-yr-old female patient presented to hospital with acute severe asthma. She was subsequently admitted to the critical care unit requiring intubation and positive pressure ventilation, back-to-back salbutamol and ipratropium nebulizers along with intravenous aminophylline and hydrocortisone. After 8 h of the above treatment her bronchospasm settled and she was extubated uneventfully. A few minutes later though, her nurse noticed that whilst her right pupil was both normal in size and in responsiveness to light, her left pupil was fully dilated. A prompt central and

peripheral nervous system examination was unremarkable. But a further detailed examination revealed that the patient was receiving her salbutamol and ipratropium through an in-circuit nebulizer system, which not only was closer to the left side of her face but also had a small leak in it.

Discussion

Ipratropium bromide is known to cause 'mydriasis' (pupillary dilation) due to its antagonizing acetylcholine at the cholinergic receptors in the eye [1]. Furthermore, the effects of ipratropium on pupils are usually due to local and not systemic absorption. Anisocoria caused by ipratropium nebulizers given via poorly fitting face masks were described in previous case reports [2]. In our case the cause of the leak of ipratropium was from an in-circuit nebulizer system. A quick and thorough bedside examination and early detection of the source of the problem saved us from performing more invasive and costly investigations.

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