PostScript

LETTERS

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Cyclizine

It has come to our attention that it is common practice within our health authority for paramedics to routinely administer to all patients with suspected cardiac chest pain, a 50 mg intravenous dose of cyclizine, as an antiemetic, in conjunction with the intravenous analgesic nalbuphine. This is the protocol in our area.

We are concerned at the use of a drug likely to increase heart rate and thus myocardial oxygen demand, in patients with an already critically ischaemic myocardium. The vagolytic effects of cyclizine are well known often with a substantial increase in heart rate.[1] Several studies have shown a direct link between myocardial ischaemia and heart rate (hence the beneficial effects of β block on high risk cardiac patients).[2] Indeed the avoidance of tachycardia and hypertension is the principal therapeutic aim of anaesthesia in patients with significant myocardial ischaemia.[3]

In guidelines published by various health authorities on the treatment of acute myocardial infarction, cyclizine is recommended as a first line drug, although a note of caution is suggested in at least one publication if the patient is thought to have left ventricular failure. It would seem to us to be more pertinent to avoid its use in patients at risk of further myocardial damage regardless of their left ventricular function.

The *BNF* reports that cyclizine counteracts haemodynamic effects provided by opioid administration and goes further to state that a common side effect is palpitations and arrythmias, surely neither being beneficial to the patient with chest pain.[4]

In our view the logical antiemetic of choice would be ondansetron, which is effective, if expensive, and devoid of serious common side effects unlike cyclizine and indeed metoclopramide.

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Public health warning: Pancake Day!

The isolated burn of the hand is a typical injury in young children and long term sequelae are not uncommon, particularly after flame and contact burns,[1] which are more prone to scarring. Children under the age of 11 years are more likely to sustain contact burns.

The paediatric accident and emergency department at St Peter's Chertsey opened its doors in the year 2000, in that time we have seen two Shrove Tuesdays (27 February 2001 and 7 March 2000) and two Guy Fawkes nights (5 November).

The number of burns treated on the 5 November totalled two cases (0, 2 respectively) and those treated on Pancake Days totalled five cases (2, 3 respectively), over double. The cases attending on Pancake Days were all burns to the hands from hot frying pan handles. Parents were present on all occasions.

Burn prevention programmes[2] and general prevention ideas such as school lectures and tests[3] need to be improved so as to highlight the risk of burns on any occasion. Regarding frying pans, manufacturers should be made aware of this hazard and look at the possibility of handles that do not conduct heat.

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CORRECTION

An error occurred in this paper by Dr M Sakr and others (2003;**20**:158–63). The correct spelling of the surname of the fourth author should be Sanders (not Saunders).

AUDIT

What is the patient's best telephone number?

Patients who attend the emergency medicine department (ED) may need to be contacted either because more information becomes available after they have left (results of investigations, radiological reports) or they fail to attend for follow up or staff have concerns about them. Typically telephone contact is likely to be made between 0900 and 1700 when EDs are best staffed and results of investigations are available.

We undertook a study to establish if the best telephone number to contact the patient between these times has been obtained by the ED receptionists. A convenience sample of 100 patients aged over 18, who had given the receptionist a contact number were then asked by one of us (LT) to give their best daytime telephone number. In 60 cases this best number corresponded with that recorded by the receptionists. For the remaining 40 patients this was not the case and it is likely that they would have been uncontactable between 0900 to 1700. Twenty four suggested a mobile number, nine a work number, and seven a home number. For the six who gave no contact number to the receptionists (because they believed a home number was being requested) five had mobile phones.

The receptionists then changed their questioning and asked for "the best daytime telephone number". A further 100 patients were then questioned. Eighty eight gave their best number to the receptionists and the proportion of mobile numbers given increased from 6% to 36%. This 28% improvement in patients giving their best number is significant (95% CI 16.5% to 39.5%) and can be easily obtained.

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