It would appear that the contents of the "Compendium" and the indications for the use of Fuller's earth have been altered since the publication of my source literature.

I was advocating the enclosure of contaminated victims within casualty pouches, merely suggesting that this is a possible response from the fire and rescue service, presented with contaminated victims of an undiagnosed type in a stressful situation. It would be understandable for them to pass the problem up the line to the receiving hospital.

I agree that the response of civilian services to any major chemical contamination incident is likely to be in the order of the extreme. There are rare events in the United Kingdom and an individual region may have never tested their plans.

That the Army has recently developed a chemical warfare ALS suggests that their responses to the chaos of such an event were deemed less than perfect.

I look forward with interest to the dissemination of the Co-operative response advice by the Defence NBC Centre but wonder if in the reality of an attack on the underground or one of the many enclosed shopping complexes in the UK, this will occur before contaminated victims arrive in an unprepared A&E department on a Friday afternoon during rush hour.

The common perception of nerve gas injury involves a great amount of fear, with visions of NBC clowns dealing with lethally contaminated victims. My aim in writing the article was to show that the treatment of such victims is logical and beneficial and well within the abilities of any qualified doctor. I also wished to point out some of the practical difficulties and offer some suggestions as to their management and I am grateful to Major Morgan-Jones and Major Hodgetts for the additional information which has not so far not been generally available to the civilian practitioner.

The authors reply:

Thank you for offering us the opportunity to reply to Dr Gibyso's comments on our paper. We are encouraged that an experienced team of psychiatry supports the use of an A&E observation ward in the management of deliberate self harm patients. Continued research in this area is important and we now keep a database of all patients who attend following an episode of DSH and are managed by the multidisciplinary team. Analysing these data base has stimulated us to look at other areas such as our case specificity, that patients presenting to A&E with drug dependency, and the management of frequent offenders, all of which can be appropriately managed by an experienced multidisciplinary team based in an A&E department.

We concur with Dr Gibyso's statement that an observation ward can improve the quality of patient care; however, further research is required in this association of a DH with drug dependency, and the long term impact of such a practice. Those of us working in A&E medicine are in a unique position to be able to study this further and should not neglect our academic responsibilities.

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Dogs, epilepsy and Airways. The dog always wins?

EDRtor—Injuries caused by dog bites are common and as many as 3 per 1000 population may attend accident and emergency (A&E) departments in any one year. 1 2 Epilepsy is also a common cause of attendance, with a prevalence in the population of 3%. However, it is rare that both problems will occur in the same patient at the same time.

Patient I was a 68 year old man with unstable epilepsy who had owned a large, but friendly, German Shepherd for a number of years. Unfortunately on the first occasion that the dog witnessed his master having a seizure it had been frightened by the attack of the large dog on its throat, causing a fracture of the thyroid and cricoideal cartilages and puncturing the trachea.

He presented to accident and emergency as a postural airway obstruction requiring an emergency tracheostomy.


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