correlation to be calculated. None of the other parameters returned abnormal findings except a mild white cell elevation. All six troponins measured were negative. The only urine toxicology screen performed was positive for benzodiazepines only and was in a patient whose history was strongly convincing for heavy mephedrone usage.

DISCUSSION

This case series forms the largest such report describing mephedrone toxicity to date. The findings support those previously reported in individual case studies and also validate predictions of a psychoactive and cardiovascular toxicity pattern, similar to amphetamine and cocaine, as the likely presentation with mephedrone in overdose or regular usage.[2 4 5 9] The predominance of anxiety, chest discomfort and paraesthesia, with a not insignificant rate of collapse, seizures and confusion all contribute to a high admission rate (51%).

It is noted that during the study period presentations related to other drugs of abuse were relatively small, only 31% of the number of mephedrone attendances even when cocaine, cannabis and heroin are combined together. This may be due to the severity of symptoms but it may also reflect the drug's usage by a naive population. Its ready availability as a 'legal high' appeared to result in its usage by groups without experience of recreational substances. They may have been unprepared for symptoms and, tallied with its 'legal' status, have been more willing to admit to its usage and seek help.

Our findings point to a pattern of addiction for this drug with patients reporting an inability to abstain after regular use.[10] In addition, users describe bingeing until exhausting supplies or the severity of symptoms forced them to seek medical attention.[11]

Although this work helps define the syndrome of mephedrone toxicity, we recognise that our qualification for subject inclusion was purely historical and lacked a formal objective test. We believe further study would be of benefit in defining the pathological effects of this drug in overdose. Any future study would ideally also contain provision for urine[6 12 13] or plasma testing both to qualify inclusion and quantify levels in subjects enrolled. This may then guide discharge decisions and help define observation periods and potential treatment protocols.

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Correction

Towards evidence based emergency medicine: PRIVATE Best BETs from the Manchester Royal Infirmary. Craig Ferguson *Emerg Med J* 2011;**28**:990. The correct title should have been published as: Towards evidence based emergency medicine: Best BETs from the Manchester Royal Infirmary. Apologises for any inconvenience caused.

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