

Short reports

The value of otoscopy

The need for a good general examination in all cases of trauma is well established, but in the region of the head and neck, examination of the ear canals and drums may be missed out when more dramatic, life-threatening injuries are sustained. This was demonstrated when a patient was admitted following an explosion in his micro-light aeroplane. The propeller was shattered, tearing off part of his left hand and embedding itself deeply into his skull and abdomen.

After resuscitation he underwent surgery under general anaesthesia by a combined team of plastic and neurosurgeons. The cranial incision extended from *Dan* to *Beersheba*, and the procedure involved resection of part of the cerebellum into which a section of the propeller was embedded.

Within a couple of weeks the patient had made a good recovery. He was left with unsteadiness, had a left-sided deafness and a left facial palsy for which a tarsorrhaphy was performed at a second operation. He later developed a discharge from the ear on the side of the impact and an opinion was sought from the ear nose and throat department. A foul-smelling discharge was aspirated under the microscope and antibiotic-steroid ear drops were administered. After a week the ear drum could be visualized more easily and what seemed like a piece of hard dried wax was seen fixed firmly up against the posterior wall of the canal. This was removed in the out-patient department and was found to be a piece of the propeller which had been



Fig. 1. Fragment of propeller that was removed from ear canal.

driven into the canal (Fig. 1) and which was being seen head-on.

After further cleaning it was apparent that there were many further smaller splinters of wood. Further cleaning and removal of splinters under the microscope has been carried out in the out patient department without anaesthetic. A third anaesthetic was not thought to be warranted, although if the size and nature of the original piece had been suspected the patient would have been readmitted for this.

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Injuries sustained by passengers on buses

Injuries sustained by passengers travelling on public buses are relatively uncommon. Public service vehicle passenger casualty rates, per billion passenger kilometre, are much lower than for cars, motor-cycles, pedal-cycles and pedestrians.¹

Thirty injured bus passengers were identified over a 4-month period. Injuries sustained by the drivers and passengers when the bus was involved in a collision were excluded.

Of these 30 patients, 21 were female (70%). The age range was from 2 to 81 years (mean age 56.8 years).

The majority of the injuries were minor, where the patients required reassurance and analgesia. However, there were two Colles fractures, one mid-shaft radius and ulna fracture, one fractured mid-shaft humerus, one supracondylar fracture of the right elbow, one fractured pelvis, one fractured rib, one fractured 5th metacarpal, two fractures of the nasal bone. The other injuries were mainly bruising and did not involve bony injury.

There were four admissions. One following abdominal injury (discharged the following day), one for fixation of the radius and ulna, one following fracture of the pelvis and a 68-year-old female who was so badly shaken that she was admitted for reassurance.

The majority of these injuries are preventable. A total of 50.3% occurred when the bus braked suddenly whilst passengers were waiting to alight, 20.3% occurred when the bus moved off quickly

causing passengers, who were waiting to be seated, having just boarded the bus, to be thrown off balance. The remaining injuries occurred whilst passengers were seated. These occurred when the bus braked suddenly causing them to hit their faces on the back of the seat in front. Perhaps these injuries could be prevented by fitting seat-belts to public service vehicles.

REFERENCE

1. Department of Transport (1991) The transport statistics in Great Britain 1991. table 1.12. HMSO, London.

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Acute psychiatric disturbance – a side effect of indomethacin therapy

Acute psychiatric disturbances are a recognized but infrequently reported side-effect of indomethacin therapy.^{1–3} We report a case of indomethacin related depersonalization.

A 38-year-old man attended the accident and emergency (A&E) department complaining of feelings characterized by episodes described as feeling as though he was 'not present'. He also could not recall having dialled 999 for an ambulance. He described the experience as being similar to a 'bad trip' that he had had with his one and only experiment with LSD at the age of 20. He was extremely agitated, but there was no delusional behaviour and hallucinations were absent. He was orientated in time, place and person. Over the previous month he had been taking indomethacin, (50 mg B.D.) by mouth for arthritis but had only taken a single dose on the day of attendance. He denied taking any other drugs or alcohol. There was no significant past or family psychiatric history. Full blood count, serum urea and electrolytes and a urinary drug screen were all normal.

He was treated with diazepam (5 mg) orally and within 30 min he felt well enough to go home. There has been no recurrence of symptoms since the indomethacin treatment was stopped. This association should be considered in the differential diagnosis of acute psychiatric disturbances presenting to A&E.

REFERENCES

1. Carmey M.W.P. (1977) Paranoid psychosis with indomethacin. *British Medical Journal* **6092**, 994–995.
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The 'light bulb' sign

The 'Light Bulb' Sign is very well recognized as being a radiological feature of posterior dislocation of the shoulder. We recently had a case where such a sign was, in fact, misleading. A 32-year-old man presented to our department having been hit by a car which was travelling at about 30 miles per hour. On arrival in the department he was complaining of pain. Clinical examination revealed him to be very heavily built with a deformed left shoulder with the classical 'square' appearance with loss of the deltoid curve, which is so typical of antero-inferior dislocation of the shoulder. Standard radiographs did indeed confirm the presence of such a dislocation which was reduced easily in the standard manner following administration of intravenous Midazolam.

Post-reduction films showed the head of the humerus to be located correctly over the glenoid fossa, however a positive light bulb sign was evident suggesting a posterior dislocation. Repeat radiographs were taken which were medically supervised employing a more conventional anatomical position. This second set of radiographs was entirely normal. The positive light bulb sign on the post-reduction film, presumably due to mal-positioning during the first post-reduction film. We have never come across a case where an antero-inferior dislocation converts into a posterior one. This case does illustrate that if a post-reduction film suggests that an anterior dislocation has been converted into a posterior one, then further films should be taken before there is any attempt as a second manipulation.

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