

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

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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.

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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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