Short reports

Breakfast bar palsy

We report an unusual variation of 'Saturday Night Palsy' with bilateral radial nerve palsy involvement. A 42-year-old man presented at the accident and emergency (A&E) department with a 1-day history of weakness and numbness in his hands and forearms. He had been drinking alcohol the previous afternoon and had fallen asleep perched on a stool with both arms leaning on a breakfast bar to support his head. He had no past medical history of note and was taking no medication.

On examination, on the left side he had slight reduction of strength (4/5) of the wrist and finger extensors, and power grip was reduced. All other muscle groups in this limb were normal, as were all tendon reflexes. There was an area of numbness on the dorsal aspect of the hand between the thumb and index finger. On the right side he had greater weakness (3/5) of the wrist and finger extensors and power grip was markedly reduced. All other muscle groups in this limb were also normal, but the brachioradialis reflex was diminished. There was an area of numbness extending in a narrow strip from the dorsal aspect of the forearm to the dorsal aspect of the hand between the thumb and index finger. The remainder of the patient's examination was unremarkable.

A diagnosis of bilateral radial nerve palsies secondary to compression was made, and the patient was discharged with volar wrist supports to improve power grip. At review 2 weeks later, he had complete recovery of the left hand and partial recovery of the right hand to 4/5 power in the affected muscle groups.

The classical 'Saturday Night Palsy' consists of a unilateral radial nerve palsy following stuporous sleep induced by alcohol and with the affected arm draped over the side of a chair.¹ Bilateral palsies are rare and it has been suggested that a generalized underlying peripheral neuropathy should always be considered in patients with such a presentation.² This case however, illustrates a clear mechanism by which bilateral sleep palsies may arise. We would recommend such patients are questioned as to their recent sleeping postures before they are subjected to further investigation.

REFERENCES

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The management of paracetamol overdose by junior doctors

Paracetamol overdose still results in 600 deaths per year and recently, the importance of correct, audited treatment of paracetamol overdose has been emphasized to prevent progression to hepatic failure.¹ We set out to review the knowledge of current management of paracetamol overdose by junior doctors in a district general hospital.

The treatment of paracetamol overdose with the antidote *N*-acetylcysteine (Parvolex, Evans Medical Ltd, Leatherhead, UK) has been established for 15 years.² In this hospital, treatment is usually initiated by junior hospital doctors in the accident and emergency (A&E) department and the commonly employed guidelines are those included in the data sheet for Parvolex. A number of factors in the history are relevant to the serum level of paracetamol at which treatment is instituted. These include enzyme-inducing drugs such as anticonvulsants, alcohol and possibly poor nutrition.

It is also now known that treatment with *N*-acetylcysteine is effective for up to 24 h after the overdose, rather than 15 h as was previously believed,³ and may even be useful in established fulminant hepatic failure.⁴

We carried out a 10-week audit of all patients who presented to the A&E department having taken an overdose of paracetamol in order to determine whether the timing of the overdose was documented, and whether medication and alcohol histories were recorded.