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. 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. 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


A.A. MILNE¹ & T.R.J. PARKE²

¹ Royal Infirmary of Edinburgh, Edinburgh and ² Glasgow Royal Infirmary, Glasgow

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. 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. 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, and may even be useful in established fulminant hepatic failure.

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.
The results show that timing of the overdose was documented in 98% of cases, medication history was recorded in 45% of cases and an alcohol history was documented in only 28% of cases. We then asked all junior doctors involved in the emergency treatment of paracetamol overdose to fill in a brief questionnaire to ascertain their level of knowledge. Our results showed that 97% of doctors acknowledged the need to obtain a medication history and 80% recognized the need to obtain an alcohol history. Of those drugs which doctors thought were important, 25 different types of drugs were mentioned, but only 15% of respondents mentioned enzyme-inducing agents.

Furthermore, only 20% knew that Parvolex could be used more than 15 h after overdose, 40% stating that it could be used up to 12 h following overdose. We conclude that junior doctors treating patients after paracetamol overdose do not always recognize factors which may potentiate the toxic effects of paracetamol, and that new guidelines on the treatment of paracetamol overdose should be more widely publicized.

The drug information leaflet provided with Parvolex does not mention the patients who may be at increased risk of paracetamol overdose, and still incorrectly states that treatment in patients who are more than 15 h post-overdose treatment is supportive only. The correct information is given in the British National Formulary. We feel that it is important that junior doctors are given accurate advice. We recommend that a full drug history should always be taken and that the new guidelines recently formulated by the UK Toxicology Group be more widely distributed and followed.5

REFERENCES

D.C. HULBERT, G.P. BRAY, M.W. BECKETT
Departments of Accident and Emergency and Medicine, The Middlesex University Hospital, Twickenham Road, Islington, Middlesex

Selenops radiata bite

A 19-year-old shop assistant, unloading a delivery of bananas that originated from the Windward Islands, noticed a spider on his hand. He felt he had been bitten, captured the spider and attended the accident and emergency (A&E) department. On arrival the patient was well with no signs of toxicity. An arachnid expert from the Natural History Museum in London telephoned and the spider was described to him. He identified it as a Selenops radiata — a form of huntsman spider that is not harmful to man. The patient was reassured and discharged. The spider was sent to the museum and the identity was confirmed.

After discussion the museum has agreed to publish the following name and telephone number for those who may require similar assistance: Mr Hillyard, Natural History Museum, London. Tel. 0171 9389123.

J.R. ANDREWS & R.J. EVANS
Department of Accident and Emergency Medicine, Cardiff Royal Infirmary, Cardiff

Fracture of the accessory navicular

The accessory navicular (os tibiale externum) is one of 21 inconsistent bones occurring in the foot situated on the postero-medial aspect of the tibialis posterior muscle. It is inherited as an autosomal dominant trait and is often bilateral.

Non-traumatic problems, caused by very large os tibiale externa, are usually linked to shoe pressure causing callosities of the skin overlying the bony prominence and bursitis. Sometimes mid-tarsalgia can be the only clinical manifestation pointing to its presence.

Sporting activities may cause traumatic involvement of other accessory bones of the foot, but acute fractures of the os tibiale externum have been reported only twice.1 We recently dealt with a 34-year-old long jumper who sustained an inversion injury to his left