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.  

REFERENCES


D.C. HULBERT, G.P. BRAY, M.W. BECKETT
Departments of 1 Accident and Emergency and 2 Medicine, The West Middlesex University Hospital, Twickenham Road, Isleworth, 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 was 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 posteromedial 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 immediately followed by eversion injury to his left
foot when he landed badly whilst practising long jump.

He presented to the accident and emergency department unable to weight bear and on examination a swollen forefoot on the medial side was evident together with excruciating tenderness over the base of the fifth metatarsal. Radiographs revealed an undisplaced fracture of the base of the fifth metatarsal and a fracture of a type II accessory navicular (Fig. 1).

A factor to consider in the management of fractures of these bones is the urgency with which the patient wants to return to physical activity and surgery is warranted if a trial of conservative immobilization management has been unsuccessful.

The patient, who was treated with a non-weight bearing Plaster of Paris cast for 6 weeks and made a full recovery, illustrates how a previously symptomless accessory bone of the foot can cause significant morbidity following sports trauma and that injuries to these bones, albeit rare, must be considered when managing foot injuries.

**REFERENCE**


M. GAVALAS, S. HARRIS & N. MAFFULLI

Departments of 1 Accident and Emergency and 2 Orthopaedics, Newham General Hospital, Glen Road, Plaistow London

**Toxic shock syndrome after burns in children**

Non-menstrual toxic shock syndrome (TSS) has received little publicity compared with the form associated with tampon use. The care of children with burns may be improved if all those dealing with them (parents as well as professionals) were aware of the clinical manifestations of TSS, to allow early diagnosis and treatment.

TSS has a high mortality rate (15%) rising to over 50% amongst patients with shock at presentation. Although uncommon, accident and emergency (A&E) staff must be aware of the problem and the possibility that TSS can occur even after an apparently trivial burn.

To establish current practice we wrote to 39 A&E departments (seeing more than 20 000 patients a year), a teaching hospital and general hospital in each region, and also to children’s hospitals with A&E facilities asking the consultant in charge two questions. Namely, (1) are your junior staff taught to give advice about the early signs of TSS to parents of children with a burn? and (2) do you have printed advice about TSS to give to parents?

Twenty replies were received. Only one indicated that their junior staff gave advice; this was supplemented by an advice sheet which contained both general advice and advice related to TSS.

We feel that A&E staff and parents should be advised about the early signs of TSS and that the most effective way to do this would be with an advice sheet. This sheet should ask the parents to bring back their child in the event of any of the following:

1. sudden fever (>39.5°C),
2. gastrointestinal upset,
3. breathlessness,
4. sore throat/pharyngitis,
5. skin problems,
6. drowsiness or confusion,
7. headache.

A&E staff should enquire specifically about the manifestations listed above and also seek further evidence of TSS for example:

1. cardiovascular disturbance — tachycardia or...