

I do not know if I am alone in noticing this problem but I would be grateful if through your columns we might instigate a debate as to how this policy might be taken forward.

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Training in major incident planning

I was very interested to read the article by Brennan *et al.*¹ I share their concerns that few doctors receive training in major incident management. Very few doctors will ever be asked to be medical incident officers by an ambulance service, but substantially more will be asked either to be part of a team sent to a major incident, or indeed a hospital medical team sent to any incident.

For the last year I have been teaching house and senior house staff of all specialties at this Hospital how to be part of a major incident team. The lecture is designed to dovetail with the plans of the London Ambulance Service, and to familiarize doctors with the command and control structures of the three main emergency services as well as to outline what is expected of the individual doctor.

As far as I am aware this is the only teaching aimed specifically at members of a mobile medical team. The lecture has proved very popular with junior staff, and I would support Dr Brennan's call for improving training of staff in major incident support.

REFERENCE

Brennan L., Sage F.J. & Simpson A. (1994) Major Incident planning in South East Thames Region: a survey of medical staff awareness and training. *Journal of Accident and Emergency Medicine* 11, 85–89.

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Contamination of clothing in accident and emergency departments

I would agree with Mr Steedman that the contamination of skin and clothing of staff working in accident and emergency (A&E) departments is both unacceptable and unhygienic.¹ The problem is not

only confined to major inner-city departments, as illustrated by the findings of survey where medical and nursing staff in the A&E department at the Royal Alexandra Hospital Paisley, a district general hospital, reported 51 splashes in a 4-week survey period during which 4692 patients were treated.

Staff most frequently splashed were A&E nurses with 51% of reported incidents (26 splashes), followed by A&E doctors at 35% (18 splashes). The remaining 14% (7) were to medical and surgical receiving staff. A total of 76.5% of splashes (39) involved blood. Although 2.6% of patients (124) were seen in the resuscitation room, 21.5% of splashes (11) occurred here. Suturing and wound management proved to be the most common cause of contamination accounting for 41% of splashes (21), which involved the trunk area in 51% (11). The practice of inserting an intra-venous cannula and withdrawing blood samples through the cannula accounted for a further 39% (20) of splashes and, of these, ungloved hands were splashed in 85% (17 incidents).

Both nurses and doctors working in A&E departments should wear protective clothing and the importance of universal precautions needs to be emphasized firmly. Many splashes could be prevented if gloves and plastic aprons were worn whilst assessing wounded patients, suturing and in the resuscitation room. Gloves should always be worn during intra-venous cannula insertion and blood sampling.

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Head injuries in the accident and emergency department

I read the article by Dr S.A. Wallace *et al.* with great interest.¹ I agree that criteria for adults when ordering skull radiographs following head injury should be modified for paediatric patients.

I would like to bring to the attention of readers recently published guidelines for skull radiographs in paediatric patients with head injury.² These are an intrinsic part of the Advanced Paediatric Life

Support Course and are a consensus view of the working group (Molyneux, personal communication).

They are, however, only guidelines and as such must be interpreted accordingly with the clinical situation and local policies.

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2. Advanced Life Support Group (1993) Advanced Paediatric Life Support. The Practical Approach, pp. 151–157. BMJ Publishing Group, London.

Ecstasy toxicity

We would like to comment on the recent case report by Roberts & Wright of 'ecstasy' (3,4-methylenedioxymethamphetamine) ingestion.¹

It is not clear why this was believed to have been an episode of deliberate self-harm. The number of tablets apparently ingested does not prove *per se* that this was an intentional overdose; pharmacological tolerance to 3,4-methylenedioxymethamphetamine occurs and some users take increasingly large amounts (T. O'Dwyer, paper presented at the Ecstasy Symposium in Leeds, 1992).

It is inaccurate to state 'deaths are usually the result of cardiac dysrhythmias'. Reported deaths include one case of ventricular fibrillation² and in others, although patients were tachycardic, death resulted from DIC and multisystem failure.

The patient described did not receive activated charcoal. This is thought to be helpful in cases of amphetamine ingestion and we believe it should be used in cases such as this.

The use of dantrolene in such patients is controversial.^{3,4} We believe that prompt correction of hyperthermia is crucial to the successful management of these patients. Active cooling and the use of a benzodiazepine (in large doses) may be part of the usual initial procedure although we appreciate that this patient required prompt tracheal intubation. Our experience that paralysis does not always correct hyperthermia⁵ is not unique.⁶ If initial procedures

do not rapidly return the temperature to normal, the use of dantrolene should then be considered. Its availability should not be a problem; sufficient quantities to treat malignant hyperthermia should be available in theatre suites (and all other areas where general anaesthesia is carried out). The basis for its use has not been established with certainty. The problems experienced after MDMA ingestion appear to have some similarities (probably being caused by central neurotransmitter imbalance) with neuroleptic malignant syndrome, for which dantrolene is a recognized treatment. One patient who survived severe toxicity, subsequently had muscle biopsy and *in vitro* muscle contracture tests carried out. No susceptibility to malignant hyperthermia was found.⁵

In summary, although we continue to believe the use of dantrolene has a role in the management of such cases, we feel the emphasis of the case report should have been on the importance of aggressive supportive care (cooling, rehydration and treatment of acidosis and other metabolic problems) and intensive monitoring.

REFERENCES

1. Roberts L. & Wright H. (1994) Survival following intentional massive overdose of 'Ecstasy'. *Journal of Accident & Emergency Medicine* **11**, 53–54.
2. Dowling G.P., McDonough E.T. & Bost R.O. (1987) 'Eve' and 'Ecstasy'. A report of five deaths associated with the use of MDEA and MDEA. *Journal of the American Medical Association* **25**, 1615–1617.
3. Watson J.D., Ferguson C., Hinds C.J., Skinner R. & Coakley J.H. (1993) Exertional heat stroke induced by amphetamine analogues. Does dantrolene have a place? *Anaesthesia* **48**, 1057–1060.
4. Webb C. & Williams V. (1993) Ecstasy intoxication: appreciation of complications and the role of dantrolene. *Anaesthesia* **48**, 542–543.
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