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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## REFERENCES

1. Wallace S.A., Bennett J., Perez-Avila C.A. & Gullan R.W. (1994) Head injuries in the accident and emergency department: are we using resources effectively. *Journal of Accident and Emergency Medicine* **11**, 25–31.
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-methylendioxymethamphetamine) 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 fibrillation[2] 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 hyperthermia[5] is not unique.[6] If initial procedures do not rapidly return the temperature to normal, the use of dantrolene should then be considered. Its avaiability should not be a problem; sufficent 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 mangement 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.
5. Tehan B., Hardern R. & Bodenham A. (1993) Hyperthermia associated with 3,4-methylenedioxyethamphetamine ('Eve'). *Anaesthesia* **48**, 507–510.
6. Singarajah C. & Lavies N. G. (1992) An overdose of Ecstasy. A role for dantrolene. *Anaesthesia*. **47**, 868–687.

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