OBITUARY

DAVID BINGHAM OLNEY
MBBS LRCP MRCS FRCS FFAEM

David Olney was a consultant in accident and emergency medicine at Milton Keynes General since 1988. He died in his sleep on the 26th July 1995, aged 45.

David’s initial education took place in Leeds. He graduated MBBS from Westminster in 1973 and spent a year in Australia working in various surgical specialties, but completed his postgraduate and higher professional training in Yorkshire. He obtained FRCS in 1980.

David was an enthusiast. He was chairman of his local Pastoral Church Council and a keen bridge player. He took an active part in local medical politics and was a member of the BMA executive committee, Milton Keynes branch, and a member of the local negotiating committee. He was chairman of the Regional Accident and Emergency Advisory Committee, a job he did with the utmost dedication and untiring enthusiasm. In this capacity, he stimulated debates and discussions on the acute hospitals of the future. He played a prominent role in the review of acute services in the East Anglia and Oxford Region.

David had a strong sense of purpose. His commitment and dedication to the specialty of Accident and Emergency was second to none.

A recent death, the A&E world has been deprived of its exceptionally capable ambassador.

K KUMAR
Clinical Director, A&E Department
Milton Keynes General Hospital

LETTERS TO THE EDITOR

An undesirable feature in defibrillators

Sir,- During a recent resuscitation attempt in our emergency room we noted a highly undesirable feature of some equipment.

Most modern defibrillators offer a choice between monitoring from the paddles or a precordial lead. The popular S&W DMS 730 defibrillator, in common with other S&W equipment—for example the DMS 750 combined defibrillator and pacer—monitors the ECG through the precordial leads if plugged in and through the defibrillator paddles if not. These machines also have three pins on the front panel which are used to test the ECG display. The precordial lead patient connectors are fastened to these pins and if the system is functioning satisfactorily an internally generated ECG trace showing sinus rhythm at a rate of 60 cycles per minute is displayed.

These pins are not meant to be used as the ‘‘resting’’ position for the patient connectors, but only to demonstrate correct function of the device.

Clearly if these test pins are used as the position of rest for the ECG lead patient connectors a spurious diagnosis of electromechanical dissociation (EMD) is risked. Recently we used one of these S&W machines and this internally generated signal was mistaken for true EMD by a well drilled team and an experienced team leader.

Clearly a test feature is desirable, but older (600 series) S&W apparatus used a rectangular waveform for this purpose. A simple change from a very convincing simulation of sinus rhythm to the previous rectangular waveform would mean that the mistake made could not be repeated. The test pins are widely used as a convenient means of ‘‘parking’’ the patient connectors.

This feature seems not to be widely understood. Any artificial simulation of normality seems a highly undesirable design feature in critical care equipment. The manufacturer tells us that they regard this as an advance over the previous rectangular waveform. We cannot concur.

It seems probable that in our case the outcome was not altered, since the correct diagnosis was asystole, but had the true diagnosis been ventricular fibrillation this ‘‘feature’’ could have cost our patient his life.

S DERBYSHIRE
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Perils of the recovery position: neurapraxia of radial and common peroneal nerve

Sir,- We wish to highlight the risk of developing a combined radial and common peroneal nerve palsy for the patient who is placed in the recovery position for a prolonged time.

A 27 year old male presented to the accident and emergency department complaining of left arm and left leg weakness. He woke up that morning to find that he was unable to use his left hand properly and his left foot felt weak. The previous night he had injected heroin in his left forearm and had been ‘‘out’’ for approximately 12 hours. On examination he was found to be fully alert, normotensive, and all peripheral pulses were normal. There was obvious left wrist and left foot drop. He was unable to extend his left wrist and had a small anaesthetic area on the dorsal aspect of the first web space. He was unable to dorsiflex his left foot and there was altered sensation over the lateral aspect of his left lower leg. All reflexes were normal and he had bilateral downgoing plantar reflexes.

There were no other abnormalities. A diagnosis of lower motor neurone palsy of the left radial and the left common peroneal nerve was made, but the mechanism remained unclear.

On taking a detailed history from the patient’s friend, it transpired that the patient had suffered an apnoeic episode after injecting heroin. He was placed in the recovery position by his friend as recommended by the Resuscitation Council London, UK.2 Upon waking next morning he discovered that he was unable to extend his left wrist, and his left foot was catching the floor. He was managed with splints and physiotherapy and made a complete recovery within three weeks.

Neurapraxia has not previously been reported in association with the recovery position. We report this case of neurapraxia involving two separate nerves that occurred...