It would appear that the contents of the “Compen’s” and the indications for the use of Fuller’s earth have been altered since the publication of my source literature.

I was advocating the enclosure of contaminated victims within casualty pouches, merely suggesting that this is a possible response from the fire and rescue service, presented with contaminated victims of an undisclosed type in a stressful situation. It would be understandable for them to pass the problem up the line to the receiving hospital.

I agree that the response of civilian services to any major chemical contamination incident is likely to be “largely in the extreme.” There are few events in the United Kingdom and an individual region may have never tested their plans.

The Army has recently developed a chemical warfare ALS that suggests that their responses to the chaos of such an event were deemed less than perfect.

I look forward with interest to the dissemination of the results of the response advised by the Defence NBC Centre but wonder if in the reality of an attack on the underground or one of the many enclosed shopping complexes in the UK, the majority of contaminated victims arrive in an unprepared A&E department on a Friday afternoon during rush hour.

The common perception of nerve gas injury involves a great amount of fear, with visions of NBC chloride or white gas, dealing with largely contaminated victims. My aim in writing the article was to show that the treatment of such victims is logical and beneficial and well within the abilities of any qualified doctor. I also wished to point out some of the practical difficulties and offer some suggestions as to how we should make use of awareness and not neglect it.

My own experience of providing a DSH service which offers assessment for colorectal patients who harm themselves would indicate that the provision of an observation ward improves the quality of psychiatric assessment and intervention. The contrast between working in casualty departments which do and do not admit DSH patients to an observation ward is often striking. Emergency assessments of DSH patients who are not deemed to warrant admission to a medical bed are frequently requested. In the absence of overnight observation beds, this often means attempting to address complex “multiple psychiatric and social problems” during the small hours of the morning, while the patient is still in crisis.

When DSH patients are admitted overnight, then a more meaningful assessment can be made the next morning, with full access to social and psychiatric support services. Patients will have had time to reflect upon recent events once they pass through a period of crisis. It is then possible to target appropriate interventions at those who will benefit most and patients can leave hospital with the appropriate follow up arrangements already in place.

There are in excess of 100 000 annual DSH admissions to the United Kingdom, and as many as 15-20% of these patients have frequent DSH within the following year. The provision of appropriate psychosocial intervention has the potential to both reduce the demands put upon A&E departments through readmission and to improve the quality of patient care offered. I believe that observation wards facilitate this process and would urge A&E departments to consider their use in cases of DSH.

The authors reply:

Thank you for offering us the opportunity to reply to Dr Gilbody’s comments on our paper. We are encouraged that an academic unit of psychiatry supports the use of an A&E observation ward in the management of deliberate self harm patients.

Continued research in this area is important and we now keep a database of all patients who attend following an episode of DSH and are managed by the multidisciplinary team. Analysing these data base has stimulated us to look at other areas such as our patient’s medication, patient’s medication, and the management of frequent offenders, all of which can be appropriately managed by an experienced multidisciplinary team based in an A&E department.

We concur with Dr Gilbody’s statement that an observation ward can improve the quality of patient care; however, further research is required in order to determine the long term impact of such a practice. Those of us working in A&E medicine are in a unique position to be able to study this further and should not neglect our academic responsibilities.

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Dogs, epilepsy and airways. The dog always wins!

EDITOR—Injuries caused by dog bites are common and as many as 3 per 1000 population may attend accident and emergency (A&E) departments in any one year. Epilepsy is also a common cause of attendance with a prevalence in the population of 3%. However, it is rare that both problems will occur in the same patient at the same time.

Patient 1 was a 6-year-old with unstable epilepsy who had owned a large, loyal dog. Her owner had been attacked by her dog on June 11, 2021, and she was rushed to the emergency department after being bitten by the dog. She had sustained a cut and a bite to her face, which required suturing. The dog had been vaccinated against rabies, and the owner was advised to monitor her for any signs of rabies exposure. The dog was quarantined for 10 days, and no further actions were required.

Patient 2 was a 7-year-old with a history of epilepsy, who was admitted to the hospital with a seizure. The patient had been taking antiepileptic drugs, but the seizure was not controlled. The patient required intubation and mechanical ventilation due to a failure to maintain airway patency. The patient was later extubated and discharged home.

In conclusion, the dog always wins in situations involving dog bites and epilepsy.