

These results were presented as a poster at the BAEM Conference in Durham in March 1996.

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- 1 Tandberg G. Glass in the hand and foot. Will an X-ray show it? *JAMA* 1982;248:1872-4.
- 2 de Lacey G, Evans R, Sandin B. Penetrating injuries: how easy is it to see glass (and plastic) on radiographs? *Br J Radiol* 1985;58:27-30.

Rollerblade injuries in children

EDITOR,—I read with interest the paper by McGrath and Beattie¹ on rollerblade injuries in children. While their paper supports many of the findings in other published reports on this subject, I would like to make several points.

Firstly, the reported operation rate is much lower than those reported by Banas *et al*² and Spicer *et al*,³ of 30% and 33% respectively, although neither of these studies was confined to children.

Secondly, they suggest the need to wear protective gear but do not tell us what percentage of their patients were wearing some form of protection at the time of injury. While wrist guards probably do help to prevent abrasions and hyperextension injuries, they may not be effective in preventing injuries caused by axial loading.

Thirdly, although the upper limb is the most common site of injury, serious injuries do occur in the lower limb, including fractures of the femur, tibia, and ankle.

Finally, it should be remembered that rollerblade injuries are not the preserve of children; Spicer's study and that of Banas both included patients aged 48 years. In a personal study from Mayday Hospital, Croydon, one patient who sustained a fractured tibia was aged 53 years of age.

As the authors suggest, we are likely to see an increasing number of rollerblading injuries in the coming years as the sport becomes more popular. The only way to keep this number to a minimum is by encouraging the wearing of protective gear, and by the teaching of rollerblade skills.

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- 2 Banas MP, Dalldorf PG, Marquardt JD. Skateboard and in-line skate fractures: a report of one summer's experience. *J Orthop Trauma* 1992;6:301-5.
- 3 Spicer DD, Mullins MM, Wexler DM. Rollerblades: should they carry a government health warning? *Injury* 1996;27:401-3.

Management of snake bite

EDITOR,—On two occasions recently we have been grateful for the help of London Zoo in managing venomous snake bites. Accurate identification of the snake concerned is essen-

tial in making correct decisions on antivenom use, and on these two occasions staff from the zoo visited the homes of the two patients within three hours of the incidents and identified the snakes.

In one case a 24 year old female, looking after a friend's snakes in her absence, was bitten on the hand and suffered extensive advancing pain and swelling. Once the snake responsible had been identified as an American copperhead we were able to obtain advice on the appropriate antivenom, which was duly given. The patient was discharged with almost complete resolution of symptoms after three days.

In the second case the owner of a number of snakes was bitten by one that he had bought illegally with only vague identification details. He presented soon afterwards with severe vomiting. The snake was identified as a Thailand spitting cobra. No antivenom was available for this, but we were able to anticipate the potential neurological complications and respiratory paralysis, which fortunately did not develop.

Although a licence is required by law before obtaining a venomous snake, many are kept without one, and traded illegally. Often these snakes are only vaguely identified. In 1994 the National Poisons Information Service (London) received 62 calls about bites from imported snakes, of which 44 were by identified snakes, of 13 different species, and 18 were by unidentified snakes. If antivenom is required, the correct one for the species is essential, as many different antivenoms are available. In this situation expert help from the local zoo can be very valuable.

For the United Kingdom as a whole, a comprehensive stock of snake bite antivenom is held in London for the south and in Liverpool for the north. These are the best points of first contact in the case of a venomous snake bite. In London the stock is held by the Medical Toxicology Unit of Guy's and St Thomas' NHS Trust at New Cross. In Liverpool the stock is held by Fazakerley Hospital, and the point of contact is the Liverpool School of Tropical Medicine. Further medical advice will then be sought by these units, from experts in Liverpool, or at the Centre for Tropical Medicine in Oxford:

Medical Toxicology Unit of Guy's and St Thomas' NHS Trust, tel 0171 635 9191

Liverpool School of Tropical Medicine, tel 0151 708 9393

Prof D A Warrell, Centre for Tropical Medicine, Oxford, tel 01865 221332; out of hours (mobile phone) 0385 242978

If help is needed with identifying the snake, the following zoos, which all have venomous snake collections, have the necessary expertise and are willing to help:

Chester Zoo, tel 01244 380280

Cotswold Wildlife Park, tel 01993 823006

Isle of Wight Zoo, tel 01983 403883

Jersey Zoo, tel 01534 864666; out of hours 01534 862198

London Zoo, Reptile House, tel 0171 449 6431; out of hours 0171 722 6450

Poole Serpenterium, tel 01202 686712

West Midlands Safari Park, tel 01299 402114; out of hours 01902 338916

Other zoos without venomous snakes but with expertise in this area include Banham, Bristol, Chessington, Drayton Manor, Edinburgh, Glasgow, and Whippsnade. Bangor University also keeps venomous snakes, in the Department of Biological Sciences under Professor Thorpe.

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BOOK REVIEW

Manual of Primary Eye Care. By Narciss Okhravi. (Pp 176; £25.00.) Oxford: Butterworth Heinemann, 1997. ISBN 0 7506 2221 0.

The majority of SHOs starting in accident and emergency medicine have little or no experience of common eye problems. As stated by the author in the preface, this book is a practical guide and not a textbook, and has been written primarily for A&E department medical and nursing staff with no prior knowledge of the subject.

Initial sections cover essential eye anatomy, the measurement of visual acuity, examination of the eye, and a useful section on the mysteries of the contact lens. The main part of the text presents readable but concise information on the management of common eye problems. Each condition is laid out in a logical manner and accompanied by photographs and illustrations of excellent quality. The star rating system for outlining the need and urgency of referral for each condition is very effective and is augmented by the use of red boxes highlighting conditions requiring immediate attention. The final section includes step by step instructions on performing practical treatment techniques such as washing out the eye or removing a foreign body. The whole text is admirably clear and free of jargon, but there is a glossary of ophthalmic terms at the end which provides a common language when communicating with ophthalmological colleagues.

The author has achieved her aim with a superb practical guide which will be of value to all primary care practitioners, whether in the emergency department or in primary health care. The book is didactic, which I think is an asset and not a fault in such a guide, but the practitioner needs to bear in mind that local protocols may vary from this text. Little background information is given and an additional textbook may be required to satisfy the inquiring mind. This is an excellent book and I have no doubt that it will be much in demand.

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