LETTERS TO THE EDITOR

Use of A&E wards

EDITOR,—I am not surprised that the physicians and surgeons at the Royal Liverpool University Hospital do not have to be convinced of the benefits of Dr A M T Good[1] organising the acute management of DVTs, ureteric colic, and acute gastrointestinal bleeds. This system, while appearing efficient, quite clearly offloads a lot of their work onto the A&E department.

The inpatient management of these acute surgical and medical admissions should not become the remit of A&E. A&E wards already take cases such as intoxicated head injuries and drug overdoses that other specialties are not interested in. So-called short stay wards can easily backfire unless strict control over admissions and patient disposal are enforced. A typical example of this is illustrated by Rainer *et al*,[2] who showed that only 84% of their patients were discharged within 48 hours of admission and three of their patients had been inpatients for more than a year!

If the medical and surgical specialties are not prepared to, or able to, organise their acute service in a proper and efficient manner, then it should not be the place of the A&E consultant to pick up the pieces. Senior A&E staff are already struggling to supervise and teach their junior staff without being burdened with other specialties' work. Dr Good's acute service may be perceived as being an exciting development for A&E, but I do not think it is one which should be encouraged.

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1 Good AMT. Current use of the A&E ward [letter]. J Accid Emerg Med 1997;14:131.
2 Rainer TH, Swann IJ, Crawford R. Critical analysis of an accident and emergency ward. J Accid Emerg Med 1996;13:325–9.

Gamma hydroxybutyrate poisoning

EDITOR,—I read with interest the case series of gamma hydroxybutyrate (GHB) poisoning reported by Ryan and Stell.[1] We have recently also seen a patient who presented with coma of unknown origin who later admitted to GHB ingestion.

A 24 year old woman was brought to the accident and emergency department having been found unresponsive by her boyfriend. He thought she may have ingested some GHB powder up to 90 minutes earlier. On arrival she was maintaining her airway but had very shallow respirations at a rate of 6/min. She had a Glasgow coma score (GCS) of 3/15, with pinpoint pupils. She was hypotensive with a blood pressure of 88/58 mm Hg. Her respiration was supported by bag-valve-mask ventilation and she was given 400 μg of naloxone intravenously and a further 400 μg intramuscularly, following which her respiratory rate improved to 16/min. Her GCS remained 3. In view of the unreliable history and possibility of ingestion of other substances it was decided to intubate her and perform gastric lavage. Shortly afterwards her conscious level improved and she opened her eyes and began to move all four limbs in a random fashion. Within three hours of presentation she had regained full consciousness and within eight hours she took her own discharge after admitting taking a combination of GHB and amphetamines.

Although GHB abuse has long been recognised in the USA,[2] until recently it has not been common in the United Kingdom. Luby *et al*[3] looked at a group of self described GHB users identified through gymnasiums. Their reasons for using the drug included body building (55%), to induce sleep (27%), to lose weight (14%), and to achieve a euphoric effect (5%).

In view of its increasing prevalence GHB poisoning must be considered in patients presenting with coma of unknown cause. The index of suspicion should be particularly high if the patient is known to be a bodybuilder.

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1 Ryan JM, Stell I. Gamma hydroxybutyrate—a coma inducing recreational drug. J Accid Emerg Med 1997;14:259–61.
2 CDC Multistate outbreak of poisonings associated with illicit use of gamma hydroxybutyrate. MMWR 1990;39:861–3.
3 Luby S, Jones J, Zalewski A. GHB use in South Carolina. Am J Public Health 1992;82:128.

Return of the bot fly

EDITOR,—We read with interest the three case reports of tropical myiasis which appeared recently in the journal.[1-3] We too have encountered the larvae of the human bot fly (*Dermatobia hominis*)—in a soldier who had been training in Belize. He presented with three large red lumps on his back, each of which had a central punctum. The respiratory tubes of the larvae were visible intermittently as they protruded through these central apertures.

However, in our (admittedly limited) experience, as soon as lignocaine was injected around and under the lesions, the bot fly larvae emerged from their bunkers in great haste. This method of removal was only described in Kitching's report.[2] It is not clear whether the lignocaine has a toxic or irritant effect or simply acts by increasing the tissue pressure to levels which the larvae cannot tolerate. Although some larvae may be less willing to leave their burrows than were our three, this simple method of extraction is surely worth attempting as it is quick, relatively painless, and gives a good cosmetic result.

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1 Bowry R, Cottingham RL. Use of ultrasound to aid management of late presentation of *Dermatobia hominis* larva infestation. J Accid Emerg Med 1997;14:177–8.
2 Kitching J. Tropical myiasis: an unwanted holiday souvenir. J Accid Emerg Med 1997;14: 178–9.
3 MacNamara A, Durham S. *Dermatobia hominis* in the accident and emergency department: "I've got you under my skin." J Accid Emerg Med 1997;14:179–80.

Dermatobia—tropical myiasis

EDITOR,—I read with great interest the three papers in your May journal reporting four cases in all of this larval infection.[1-3] May I add two more?

A year ago a 70 year old man was referred privately to me as an emergency. He had returned from Costa Rica with pain and swelling of his left wrist. A small discharging hole was visible and a lump palpable. I removed this lump. The pain went. He was healed.

Subsequent examination, by a professor of etymology, identified *Dermatobia hominis* "with enormous hooks on the second instar larva." He wrote "One of my students had two of these following an expedition to Peru. They are agonisingly painful when they move inside the sinus."

These reports of six cases show that with more worldwide travel these larval infestations are now commoner in the United Kingdom. They present as emergencies, particularly when the pain is acute.

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1 Bowry R, Cottingham RL. Use of ultrasound to aid management of late presentation of *Dermatobia hominis* larva infestation. J Accid Emerg Med 1997;14:177–8.
2 Kitching J. Tropical myiasis: an unwanted holiday souvenir. J Accid Emerg Med 1997;14: 178–9.
3 MacNamara A, Durham S. *Dermatobia hominis* in the accident and emergency department. J Accid Emerg Med 1997;14:179–80.

BOOK REVIEWS

Management of Injuries in Childhood.
By John F T Glasgow and H Kerr Graham. (Pp 423; £34.95.) London: BMJ Publishing Group, 1997. ISBN 0 7279 0925 8.

At last, increasing attention is being paid to the causes and treatment of paediatric injuries—although the focus is still mainly on the relatively rare major injury rather than the routine, though equally frequently mistreated, minor injury. Inevitably, training and textbooks lag behind trends, but this book makes a good attempt to fill the vacancy for a reference work on all types of injuries affecting children. It is a comprehensive guide to the diagnosis and treatment of major and minor injuries, with a considerable emphasis on the detection of child abuse; although opinions may vary as to the importance of the latter, the authors' balance is probably appropriate at this stage in the development of treatment of paediatric trauma.

When the review copy arrived I was in the middle of preparing lectures on the treatment of minor injuries, to give to our trainee nurse practitioners. I found the well laid out information and tables for assessment and management of bruising, abrasions, and lacerations saved me a lot of time—and a fair amount of original thought. These minor though common problems are likely to be the prime concern of nurse practitioners, yet are usually omitted from conventional textbooks. The section on classification and description of fractures is clear and should help a junior doctor in A&E or paediatrics to communicate with the orthopaedic staff; at worst, the registrar will think the house officer knows what they are talking about! Bony injuries are discussed by anatomical area and give good

guidance on examination, range of diagnoses, investigation, and management required. The authors also point out likely missed or wrong diagnoses and possible errors in management. I particularly liked the section on elbow injuries—which can be difficult to identify anatomically.

The book is, inevitably, considerably weaker in areas where the authors have less direct expertise. The chapters on epidemiology and accident prevention, although giving a rounded approach, add little that did not seem self evident; perhaps I like to keep the numbers up! The chapter on medicolegal reports is very sketchy, for what is a whole subject in itself, and concentrates on child abuse reports. Since this is written for junior doctors, I would have liked to see a short paragraph on those instances where a doctor should decline to provide a report—especially to coroners and the police. Presently somewhat obese, the loss of the 71 pages that these chapters occupy would lead to a book that fits in the pocket of that new white coat, and thus make it much more likely to be carried by my SHOs.

In conclusion, this is an extremely readable, concise, and informative volume, strongest on the diagnosis and management of soft tissue and bony injury. Because the authors have tried to make it appeal to a very wide selection of medical specialties I feel that some of the chapters detract from the central aim. Despite that, it is still be a very useful reference—and one with no obvious rivals—to have available for junior doctors in either general or paediatric A&E departments.

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Cambridge Textbook of Accident and Emergency Medicine.

Edited by David Skinner, Andrew Swain, Rodney Peyton, and Colin Robertson. (Pp 1271; £120.00.) Cambridge: Cambridge University Press, 1997. ISBN 0 521 43379 7

One of the potential problems with large textbooks is that they take so long to compile, and the information becomes out of date almost before the book reaches the printers. It is a great pleasure, therefore, to find that the *Cambridge Textbook of Accident and Emergency Medicine,* certainly a major work at 1271 pages, is very much up to date in its content. The scope of accident and emergency medicine, often poorly understood by colleagues in other specialties, is well defined by this book.

No book can be perfect, but my criticisms will be brief. On a technical note, the paper is somewhat thin and text, diagrams, and photographs can be seen through the pages, a feature which is particularly irritating in the radiology and emergency imaging section. This is a great pity, since the quality of the graphics in this section is otherwise excellent.

It could be claimed that many sections are "written by experts," but there are certain pitfalls in this. For example, the sections dealing with orthopaedic injuries are strong on classification and later management, but weak in their coverage of immediate assessment and modern methods of splintage and immobilisation. The chapter covering major incidents contains a good review of past disasters, but is relatively weak on background information, with old references and no discussion of national sources of guidance.

To come on to the positive features, this book certainly reflects the present state of the art in accident and emergency medicine. Discussions of high science, with few exceptions, keep practical applications in view. Discussions of patient management emphasise clinical methods rather than highly sophisticated investigations (which may not be accessible to all departments) and give a true reflection of British practice.

In view of rapid developments within specialty, the editors and contributors will be condemned to an endless cycle of updating for new editions, but the freshness of this first edition is a good boost.

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