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munity has used the service, and interestingly clients of all ages attended for treatment. Altogether 98% of the patients surveyed were happy to be seen by a nurse and were satisfied with the treatment they received. The level of transfers, referrals to clinics, and the number of clients treated by the ENPs suggest that all the fears and scepticism expressed before the start of the service appear to be unfounded.

The authors conclude that this study has demonstrated that given suitable training, protocols, and close liaison with a neighbouring A&E department, nurses can provide an effective and worthwhile locally based service.

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workload as well as that arising from events such as this. Despite a 50% increase in A&E medical and nursing staffing levels, the temporary use of an extra observation ward and medically manned first aid stations at the party site, the huge patient numbers created major problems for both the A&E department and hospital facilities.

The natural focus of the Hogmanay celebrations was midnight on 31 December, but a myriad of additional events took place over several days on either side of this. The greatest patient numbers presented between 11 pm on New Year's Eve and 5 am on 1 January, but significant peaks occurred when patients presented later that day and again on 2 January (fig 1). This protracted nature of patient presentation led to prolonged and unremitting strain on staff and resources.

Alcohol intoxication was ubiquitous and was the single most important factor compounding the situation. Many patients and their relatives and friends were uncooperative and abusive. Difficulties were posed by even simple processes of care such as undressing patients, taking baseline recordings, *x* ray imaging, and instituting treatment. A permanent police presence was needed in the department over the three day period to protect staff and patients against violent outbreaks.

The inherent safety of the Hogmanay celebration is questionable. This year, underfoot conditions were hazardous because of snow. Crowd barriers and railings were bent by crowd pressures and the potential for a true major incident as a result of crushing injury is ever present. Subsequent press and personal reports emphasised the "appalling, dangerous crush" and "Hillsborough all over again."[3 4] Major delays in transporting patients by ambulances were reported, and if life threatening injuries had occurred, access would have been difficult for ambulance and medical crews.[5]

Plans are proposed to increase the numbers attending to over 500 000 for the millennium celebrations. At what point does encouraging people to have a good time constitute reckless irresponsibility?

We wish to acknowledge the help of Dr Colin Robertson in preparation of this paper and the extraordinary efforts of all members of staff in the accident and emergency department during the Hogmanay period.

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indication for skull *x* ray—none of these had sustained a fracture. Of the remaining 186 frontal head injuries there were two skull fractures and both of these had other indications for skull *x* ray.

Conclusions—Guidelines for skull *x* ray following paediatric head injury, particularly when the sole indication is soft tissue swelling, contusion, or haematoma following frontal injury, needs re-evaluation.

A case of severe hypertension complicated by intracerebral haemorrhage and acute pulmonary oedema

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A 54 year old man collapsed unconscious at home. On arrival at the accident and emergency department he was breathing spontaneously at a rate of 36 per minute and had a pulse of 84 beats per minute. His blood pressure was 300/140 mm Hg by both manual and automated methods. There was no appreciable difference in the pressure recorded between right and left arms. Glasgow coma score was 4 with extensor response and his pupils were equal but unreactive.

In the past he had apparently been investigated for diabetes and had been prescribed atenolol for hypertension. He had suffered no significant previous illnesses and was a non-smoker.

His blood pressure rose steadily reaching a peak of 340/280 mm Hg but his pulse remained at around 80 beats per minute. Electrocardiography showed left ventricular hypertrophy with strain. He then developed acute pulmonary odema with copious, pink frothy sputum. He was given intravenous frusemide and was incubated and mechanically ventilated as his respiratory effort was deteriorating.

A working diagnosis of malignant hypertension complicated by probable intracerebral haemorrhage and acute pulmonary odema was made but phaeochromocytoma could not be excluded. After consideration of various antihypertensive agents he was commenced on sodium nitroprusside infusion and his blood pressure gradually fell to 200/150 mm Hg.

Computed tomography was performed which showed a large right parietal haematoma with mass effect and midline shift. This was not operable so he was transferred to ITU where he died 36 hours later.

Points for discussion: (1) Should we have worried about the possibility of phaeochromocytoma? (2) Did we use the most appropriate antihypertensive agent? (3) What level of blood pressure should we have been aiming to maintain?

Heart failure out in the cold: the risks of an ecstasy tablet

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A young man was brought to the accident and emergency department in extremis by his friends. He had a respiratory arrest shortly after arrival due to gross pulmonary oedema and required immediate intubation and ventilation. He was found to be hypothermic with a core temperature of 30°C.

It later transpired that he had earlier ingested an ecstasy tablet and gone to sit outside because he felt unwell. He was found several hours later. His cardiac failure was associated with myocardial stunning. After a prolonged ITU admission he was discharged home.

Ecstasy is normally associated with hyperpyrexia. This unusual presentation is a reminder that drug intoxication may not present in a textbook fashion. The effects of ecstasy and the proposed hypothesis for the way in which this man presented are discussed.

Emergency Medicine

A reciprocal arrangement has been set in place with the *Journal of Accident and Emergency Medicine* and *Emergency Medicine* whereby the contents pages of the *Journal of Accident and Emergency Medicine* and *Emergency Medicine* will be published in the respective journals.

The contents page of *Emergency Medicine Volume 10, Number 1* appears below.

Emergency Medicine — March 1998, Volume 10, Number 1

A 20 year old male attended the accident and emergency department with a six hour history of increasing agitation and hyperactivity, associated with feelings of impending death and visual hallucinations. Fourteen hours previously he had swallowed four whole nutmegs and half a litre of vodka for a "buzz". Five hours after ingestion he experienced a tingling feeling in his hands and feet, which later spread to his whole body. He felt "detached from the world" and stated that everything appeared to move in slow motion. He subsequently experienced dry mouth, thirst, nausea, palpitations, and dizziness. This progressed to the state of high agitation in which he presented.

Physical examination revealed a flushed, agitated young man, fully orientated, with a tachycardia of 130/minute, blood pressure of 120/85 mm Hg, and a respiratory rate of 24/minute. He was apyrexial. Pupils were dilated (size 4), reacting briskly to light and accommodation. Neurological examination revealed hyper-reflexic upper and lower limbs. The remainder of the physical examination was normal.

Electrocardiography revealed a sinus tachycardia and laboratory investigations were normal. He was admitted for observation. His altered mental state persisted for 18 hours after admission (32 hours after ingestion) and the sinus tachycardia resolved after 20 hours. He was discharged 36 hours after admission, with psychiatric follow up arranged.

The spice nutmeg has long been used for purposes other than culinary. Not least among these is its use as a recreational drug, based on its purported euphoric and hallucinogenic properties.

Nutmeg's use in this context stems from the Crusades, and it has also been a well documented substance of abuse among prison inmates.[1] Nutmeg ingestion gained currency during the 60s and 70s, when it was touted as a cheap alternative to alcohol and other mind altering substances. Most of the published case reports date from this time, and describe toxic effects similar to our case.[2] The clinical course is generally benign and management is largely supportive, although cases complicated by hypotension, cyanosis, acidosis, coma and, in one instance, death have been reported. Hypertension can be treated with phentolamine, but sedatives should be used with caution as they may cause alternating drowsiness and delirium (information from the National Poisons Information Centre, Beaumont Hospital, Dublin, Ireland). Nutmeg comprises 5–15% volatile oils, of which myristicin is the largest fraction. Myristicin is metabolised to 3-methoxy-4,5 methylenedioxy-amphetamine (MMDA), a psychoactive sympathomimetic. It is postulated that this accounts for most of nutmeg's toxic effects.

While historically nutmeg appears to have enjoyed a reputation as a hallucinogen, in circumstances where the spice is taken in excess, a typical and unpleasant clinical syndrome ensues. This, presumably, is why nutmeg abuse is virtually unheard of nowadays, with teenagers more likely to encounter it at the dinner table than on the street corner.

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1 Schulze RG. Nutmeg as an hallucinogen. N Engl J Med 1976;294:849.
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CS spray

EDITOR,—Breakwell and Bodiwala's article on the consequences for an accident and emergency (A&E) department of CS spray exposure is timely.[1] In 1996 the police service in England and Wales carried out a six month trial of CS aerosol incapacitant in selected forces.[2]

Police surgeons were involved in submitting reports where consent was given on the medical condition of those sprayed. Due to the involvement of the members the Association of Police Surgeons produced an information sheet *Crowd Control Agents: Clinical Effects and Management.*[3]

In August 1996 the Home Secretary announced his support for any chief officers of police wishing to issue CS to officers on the beat. Within the London area police officers are now being trained and the incidents of exposure are likely to increase.

A person arrested who has been sprayed with CS incapacitant spray will be examined by a forensic medical examiner (police surgeon) as soon as possible. However members of the public who may be involved are likely to present themselves to A&E departments for advice. It is most important therefore that A&E staff are prepared to deal with the clinical effects of crowd control agents.

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1 Breakwell A, Bodiwala GG. CS gas exposure in a crowded night club: the consequences for an accident and emergency department. J Accid Emerg Med 1998;15:56–7.
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"Shop hopping"

EDITOR,—Napoleon called us a nation of shop keepers. We are now, I believe, a nation of shoppers. Some people shop unfunded. We call then shoplifters. They rely on a combination of stealth, speed, and occasional force. Here are two cases of a variant of shoplifting that I call "shop hopping". A shop hopper is an individual with a habit of regularly faking collapse in shops to avoid payment.

Case reports

CASE 1

Elizabeth presented to our accident and emergency department at the Derbyshire Royal Infirmary in 1979. She had no general practitioner. She had a respiratory tract infection. She received antibiotics and soon recovered. She then was brought to our hospital practically every few days by the ambulance service for the next four years. The story was always the same. She "collapsed" with her shopping at the checkout of a food store. An ambulance was called. Well meaning shoppers put her shopping in the ambulance too—all unpaid for. Once in our department, she usually recovered quite quickly and walked home. She lived nearby and rarely stayed long enough to be examined. No medical cause was ever found for these timely attacks. She became well known to all the emergency crews on the ambulances and was also well known to our staff. One of our sisters even shouted to her to "get up and get out" in Sainsburys. It worked that time but did not cure the habit. (The sister was nearly lynched.) The last time I saw Elizabeth she had collapsed with a stroke; she died soon after.

CASE 2

Patricia presented to our department recently with chronic back pain demanding analgesia. She had just come from Scotland and already had had a row with a general practitioner locally. She then expressed suicidal intent and was referred to a psychiatrist. Telephone calls to other hospitals confirmed her to be a "hospital hopper". However, the ambulance services of several counties knew her better as "the lady who collapsed in food stores at the check out". She then obtained free food as they conveyed her in comfort to the local hospital; this happened many times. She had come south on a shop and hospital hopping spree!

These two cases illustrate the habits of a "shop hopper". Neither patients had a good relationship with a general practitioner. These patients are a type of "hospital hopper", who purposely abuse the ambulance and hospital services for their gain. We, the taxpayers, foot the bill. Circulating pictures of such patients to shops would breach medical etiquette. Challenging such patients in a store does not cure them. The store cannot send a bill to the patient as the goods have not been through the till. The ambulance service cannot "boycott" these people as they have a duty to convey collapsed patients to a hospital. We doctors have a duty to examine all such patients. Such a collapse may be genuine. Once in a hospital, recovery is rapid, and they take their own discharge prior to the police arriving. Shops, hospitals, and the police need to recognise these people and become more vigilant. I cannot think of a better way to shop!

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Management training for specialist registrars in accident and emergency medicine

It has been noted by the Examination Board of the Faculty of Accident and Emergency (A&E) Medicine that recent entrants for the fellowship displayed a weakness in their knowledge of management issues. This has prompted a group of consultants within the Yorkshire Region, who are involved in specialist registrar training, to look at the issue of management training for specialist registrars in A&E medicine.

Concerned at the lack of dedicated management training for doctors in the specialty and following the success of the management training scheme at St Bartholomew's Hospital in London, along with the recent report presented to the Academy of Royal Colleges of the United Kingdom by Professor Cash, President, RCPE, and Dr Lindsay Burley, FRCPE and General Manager of the Borders Health Board, it was felt that the lack of training in relation to management and management issues should be addressed as a matter of high priority. They have decided to organise a five day residential course on management training to be held in the region, supported by the Yorkshire Deanery of the University of Leeds (Postgraduate Medical and Dental Education).

The report, presented by Professor Cash, was given unanimous approval for implementation throughout the UK and in all medical specialties; it centred around identifying ways of assisting doctors to contribute effectively (in their current and futures roles) to the increasingly complex and changing NHS. This underlines the belief by the Yorkshire consultants in the need to provide management training to the specialist registrar (A&E), not only in their region, but to provide the opportunity for specialist registrars (A&E) elsewhere in the UK to have the opportunity in attending the course.

The course programme has been carefully put together based on the core curriculum proposed by the Academy of Royal Colleges and draws upon the experience and expertise of recognised experts in the field of management generally and clinical management within the NHS, as well as the syllabus for the Fellowship of the Faculty of Accident & Emergency Medicine.

The programme includes workshops and lectures with speakers drawn from senior consultants and managers in the NHS and experts in the appropriate areas, and will be supported by information technology and administrative staff throughout the course.

This innovative course is the first of its kind in the north of England and it is anticipated that the course will be held annually in order to secure the long term training needs of specialist registrars in the specialty of A&E.

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Royal Hull Hospitals Trust
S M BARNES
Dewsbury Health Care NHS Trust

Specialist registrars (accident and emergency) management training course

A five day residential course will be held at Harrogate on Monday 21 to Friday 25 September 1998.
This course is for the specialist registrar in his/her 4th/5th year aiming for their CCST.

Day 1—political and economic issues; funding and contracting; the future; introduction to work groups
Day 2—organisation styles; leadership skills; team building
Day 3—complaints; media and public relations; criminal negligence scheme for trusts
Day 4—employment law; recruitment selection; interview techniques
Day 5—policy and guidelines; use of information; audit and charter standards

The course has been designed specifically to provide the specialist registrar with an intensive, proactive, and interactive experience of management within the NHS.

The aim is to ensure that the requirements and criteria for the CCST curriculum are covered and that the delegate is provided with a good, solid foundation of basic management skills.

It is anticipated that the course will ensure that the specialist registrar will be able to contribute effectively tothe developing NHS, by understanding all levels of the NHS organisational structure and understand the role of the A&E consultant.

Fee: £800.00 inclusive of accommodation (full board).

Venue: Quality Kimberley Hotel, Harrogate (car parking available).

Further details: Mrs Jacqueline Brayshaw (Course Administrator), "Wheatcroft", Main Street, Great Hatfield, East Yorkshire HU11 4US (tel/fax: 01964 536821).