

# PostScript

## LETTERS

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## A computerised log for the emergency department resuscitation room

Resuscitation is a key activity of the emergency department (ED), yet routine reporting is rare. We previously used a handwritten log but found it to be incomplete. Data analysis was labour intensive. Data from agencies outside the emergency department were not recorded and staff found little opportunity for critical incident reporting.

We created a simple Microsoft Access database that enabled the collection of patient, clinical, and episode details. Outcome and discharge data were added using the hospital computer system and ICD10 coding. Prehospital information was also recorded.

The following benefits were noted:

- Data collection was more comprehensive (perhaps due to mandatory fields in the electronic log).
- Trends in patient care prompted earlier review and changes in management.
- Critical incident recording was an integral part of the log and has been used to change practice.
- Recording the numbers and grades of both nursing and medical staff in the resuscitation room has been influential in making a case for additional staff.
- Use of databases for "hot" review in a teaching environment enables identification of important learning points.
- Selective analysis of the data is now rapidly available to a variety of interested parties, for example, ED staff, paramedical staff and inpatient teams.
- A separate screen for the prehospital phase of patient care has encouraged paramedics to enter data and has facilitated a review of previous cases.

- Each middle grade doctor has a training record of cases seen and procedures performed.

This simple, inexpensive, flexible electronic resuscitation log has become an integral part of our department. We would suggest that other departments consider this system if they do not already have one in place, and we would be happy to answer any inquiries.

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## Mad as a hatter

I read with interest the case report by Poulden.<sup>1</sup> In 1993 Dr Roden and I reported a case of deliberate self injection of mercury resulting in abscess formation and mercuric emboli to the lungs.<sup>2</sup> In our case a 27 year old doorman of a local casino presented with a swelling of the arm. (He was a keen body builder 1.90 m in height and weighed 107 kg). On the flexor aspect of his forearm there was a 4×5 cm fluctuant swelling. The casualty officer drained this abscess and out came mercury! A radiograph of the forearm (fig 1 in the case report) showed the mercury and radiographs of the skull and chest demonstrated micro emboli.

Serial blood and tissue mercury levels were raised but not toxic. We treated him with penicillamine and excised the abscess on the forearm under a general anaesthetic. He remained well. He denied putting the mercury in himself and revelled in any attention.

Three months later he returned complaining of a "head injury". There was a small wound on his forehead. Radiographs showed a bullet in his skull and computed tomography showed a large frontal haematoma. He was operated on by neurosurgeons and then referred to the psychiatrists.

Deliberate poisoning by self injection of mercury as a suicide attempt was first reported by Umber.<sup>3</sup> There are about 30 such cases in the literature with three fatalities reported. However, deliberate injection of mercury to obtain strength has also been reported.<sup>4</sup> Our patient admitted eventually that the gunshot wound was a suicide attempt and the injection has been thought to give extra strength to body builders.

These two cases, the ingestion reported in *Emergency Medicine Journal* and injection reported in *Injury*, illustrate that the emergency doctor has to be ever vigilant as some

of our patients do strange things. In both cases there was a delay in obtaining the blood mercury concentrations. The patient who ingested mercury had a higher level of mercury than the one who injected himself! There is little correlation between the volume of mercury injected and the outcome—2 cc has been fatal<sup>3</sup> and 20 cc non-fatal.<sup>4</sup>

The term, "mad as a hatter" is thought to have derived from madness induced in hatters from contact with mercury. However, those who ingest or inject mercury can hardly be termed "normal".

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## References

- 1 Poulden M. Mercury: Is it elemental my dear Watson? *Emerg Med J* 2002;19:82-3.
- 2 Roden R, Fraser-Moodie A. Self-injection with mercury. *Injury* 1993;24:191-2.
- 3 Umber F. Quecksilber-Quecksilber-Embolien des lehender durch intraverose injektion vol metallis chen silber. *Med Klin* 1923;19:35.
- 4 Celli B, Khan MA. Mercury embolisation of the lung. *N Engl J Med* 1976;295:883.
- 5 Johnson HRM, Koumides O. Unusual case of mercury poisoning. *BMJ* 1967;1:340-1.

## NOTICES

### Medic 1 Trust Fellowship

The Medic 1 Trust Fellowship is awarded to facilitate education or research in the field of accident and emergency medicine and may be used for associated travel. The Fellowship is awarded to a doctor or nurse currently working in the field of accident and emergency medicine. The value of the award will be a maximum of £2500. A maximum of one medical scholarship and one nursing scholarship will be made every year. Applications must be received by 28 February 2004. Further details: Chairman of the Medic 1 Trust, c/o Maclay Murray and Spens Solicitors, 151 St Vincent Street, Glasgow G2 5NJ, UK.

### 10th International Conference on Emergency Medicine

The 10th International Conference on Emergency Medicine will be held at the Cairns Convention Centre, Queensland, Australia on 6-10 June 2004. Further details: Sonia Higgs, Conference Manager (email: [icem2004@im.com.au](mailto:icem2004@im.com.au); (tel: +61 7 3858 5535; fax: +61 7 3858 5510; and web site <http://www.icem2004.im.com.au>).