

topic of them all. The authors have also avoided a specific section on induction drugs and paralytic agents, although there are periodic references scattered throughout the text.

Illustrations are of varying quality; the colour photographs are generally very good, the line drawings are clear, but many of the black and white photographs are reduced to an excessively small size and it is difficult to make out the points they are intended to clarify. There are three photographs (and a biography) of Archie Brain, and with due regard to his achievements, I am not persuaded that this is necessary in a 209 page core topics book.

In short, although there are some good chapters in this book, there are "core topics" which are key to the emergency medicine doctor which are completely missing. I personally think the missing topics should also be key to anaesthetists—but I am not sure if I could get away with such an assertion. I'm afraid I would not recommend this book for emergency medicine doctors.

Neil Nichol

## CORRECTIONS

doi: 10.1136/emj.2006.041236corr1

Puranik G, Gillham N. Bilateral fractured clavicles with multiple rib fractures. *Emerg Med J* 2007;**24**:675.

An error has occurred within the third column of this Image in Emergency Medicine. On line 3, ORIF should read as "(open reduction and internal fixation)".

doi: 10.1136/emj.2007.051334corr1

McEwan K, Thompson P. Ultrasound to detect haemothorax after chest injury. *Emerg Med J* 2007;**24**:581–582.

An error has occurred in this Best Evidence Topic report (BET) on page 581. In line 9 of the Comments section, the sentence should read as follows:

When compared directly to the supine chest x ray, ultrasound is shown to be more sensitive

at detecting the presence of the haemothorax and is at least as specific and accurate.

doi: 10.1136/emj.2007.053819corr1

## NOTICE OF DUPLICATE PUBLICATION

Sultan J, Curran AJ. The effect of warming local anaesthetics on pain of infiltration. *Emerg Med J* 2007;**24**:791–793 (doi:10.1136/emj.2007.053819).

The above Best Evidence Topic report (BET) published in volume 24, issue 11 (November) is a duplicate publication of the same report published in volume 24, issue 10 (October) as follows:

Sultan J, Curran AJ. Effect of warming local anaesthetics on pain of infiltration. *Emerg Med J* 2007;**24**:723–725 (doi:10.1136/emj.2007.053223).

The publisher apologises and is withdrawing the version published in the November issue (doi:10.1136/emj.2007.053819).

## IMAGES IN EMERGENCY MEDICINE

# Fracture of the posterior process of the talus: an unusual injury

R Ahmad, S M Y Ahmed

Most attention in the literature has been devoted to fractures of the neck of the talus, whereas fractures involving processes of the talus have been relatively neglected. Consequently, questions persist regarding these fractures and misdiagnosis is common.

A woman in her 50s slipped off decking and landed with her foot in hyper planter flexion sustaining a fracture of the posterior process of the talus (fig 1). This was treated conservatively.

Fracture of the posterior process of the talus is rare and is often misdiagnosed as ankle sprain. In one case series, 17 of 20 patients with fractures were misdiagnosed with ankle sprains.<sup>1</sup> It is most likely caused by forceful plantar flexion of the ankle producing a nutcracker-like compression of the posterior process between the posterior malleolus and the calcaneus.

An understanding of the complex anatomy of the hind foot is required.

The clinician must be knowledgeable in the interpretation of plain radiographs and in the use of additional studies, such as CT scans. Failure to diagnose and initiate proper immobilisation frequently results in painful non-union and disability.

*Emerg Med J* 2007;**24**:867.  
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Figure 1 X ray and CT scan showing fracture of the posterior process of the talus.

## REFERENCE

- Paulos LE, Johnson CL, Noyes FR. Posterior compartment fractures of the ankle. A commonly missed athletic injury. *Am J Sports Med* 1983;**11**:439–43.