Death in patients with hyponatraemia is often related to the underlying medical disorders (Arieff *et al.*, 1976; Kleinfeld *et al.*, 1979; Flear *et al.*, 1981). Delirium and seizures are common presenting features. Hyponatraemia causes neurological symptoms when serum sodium levels are below 120 meq/l and even more frequently when below 110 meq/l. Immediate treatment is indicated when patients present with confusion, seizures, shock and in a comatose state (Flear *et al.*, 1981; Thomas *et al.*, 1978; Ayres *et al.*, 1985). Many of the symptoms which are seen are thought to arise from cerebral oedema (Tomlinson *et al.*, 1979; Arieff, 1985).

We present this case to highlight the importance of measuring serum sodium in all confused patients but particularly in alcoholics, in whom hyponatraemia is associated with a mortality of 86% (Thomas *et al.*, 1978; Baron & Hutchinson, 1983).

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Hand injury review clinics

Sir

I read with great interest the article by Cutting & McLean (*Archives of Emergency Medicine* **4**, 211–17). I would like to congratulate them on the successful running of their clinic.

The Hand Injury Review Clinic at East Birmingham Hospital runs on very similar

lines, with the exception that it occurs daily, instead of weekly. I found in my review of this clinic (Finlayson *et al.*, 1986), that it served a very useful purpose in reducing morbidity from hand injuries, ensuring early and correct definitive treatment of hand injuries and in teaching the Casualty Officers about the management of such injuries. A daily Hand Injury Review Clinic also runs in the A&E Department at Queens Medical Centre.

I would like to recommend that clinics such as these should be more widespread.

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Thrombolytic therapy for myocardial infarction—our role

Sir

Thrombolytic therapy may be a major advance in the treatment of myocardial infarction (MI) and accident and emergency (A&E) should become a key service when it becomes accepted practice (Smith & Eisenberg, 1987).

The logic of thrombolysis is:

- (1) 85% of transmural myocardial infarctions are caused by thrombosis or an atheromatous plaque (Smith & Eisenberg, 1987);
- (2) the clot can be lysed by streptokinase, tissue plasminogen activator or acylated plasminogen activator (DeWood *et al.*, 1980); and
- (3) the myocardium can resume function if it is reperfused within 6 h (DeWood *et al.*, 1980).

A number of clinical studies indicate that thrombolysis can reduce the early (21-day) mortality from MI by one fifth, if it is started within 6 h of onset of pain (Kennedy *et al.*, 1985; TIMI, 1985). If started within an hour, the early mortality is halved. This reduced mortality continues for a year (GISSI, 1986). Those persons under 65 developing their first anterior infarct on ECG, seem to benefit most. Intravenous streptokinase in a loading dose followed by infusion up to a total of 1.5 million units over an hour is commonly used. Minor problems of bleeding, hypotension and allergy are noted.

In the next 5 years, thrombolysis will gain further acceptance. It is crucial that the A&E department is seen to be able to respond rapidly with trained staff in well-equipped resuscitation rooms. The patient with chest pain can be monitored, the parameters for starting thrombolysis identified (for example, ST elevation) and the intravenous therapy commenced within minutes of arrival.