

Results of a survey of 44 consecutive patients attending the Smokers' Clinics of the Central Sydney Area Health Service

- 43% currently using "chop-chop"
- 84% smoke it because it is cheaper
- 58% believe it is better for you
- 74% believe it has no additives
- 16% believe it has no nicotine
- 63% know it is not legal

the Central Sydney Area Health Service (approved by the CSAHS Ethics Committee, June 2002). Patients were routinely asked the type of tobacco they smoked and their beliefs regarding this type of tobacco. The results are shown in the Box.

Many of the patients attending the Smokers' Clinics (dedicated exclusively to patients who smoke and have chronic obstructive pulmonary disease [COPD]) smoke this type of illegal tobacco. Several patients volunteered that smoking chop-chop precipitated an acute exacerbation of their COPD. Four patients have recently presented to a hospital emergency department for exacerbation of COPD after smoking chop-chop. Although smokers are loath to volunteer their use of this illegal tobacco, smokers and clinicians should be warned that smoking chop-chop does not constitute a positive health move, is not less harmful, and may be quite dangerous. Quitting smoking altogether is the best health move.

Competing interests: None identified. □

The altered whistle in tetanus

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TO THE EDITOR: These two cases, which occurred many years ago, illustrate a useful clinical sign in the diagnosis of tetanus.

An elderly man was admitted to hospital after crushing his finger in a stable door. He commented in passing that when he whistled across the park to his wife that morning, she had not heard him. However, she had heard him the previous two mornings. He was a professional whistler on the radio and, when asked, still appeared to produce a good strong whistle. As it is the high pitch that carries long distances, I pondered the causes of selective pitch loss. I suspected the "risus sardonius" of tetanus. He was subsequently confirmed to have tetanus and survived.

Years later, a middle-aged woman with right hypochondrial pain and presumed cholelithiasis presented to a country hospi-

tal for a cholecystogram. I chatted to her about her bandaged hand — she said that she had cut it on a jam tin in her house, but that her general practitioner was treating it, and all her vaccinations were up-to-date. Some hours later she complained that her abdominal pain was worse and had moved. I believed that the pain was probably related to movement of gallstones, but was more interested in her hand wound, of which she was dismissive. I asked her to whistle. It was a good whistle, but she commented, "It's not my whistle, I whistle the cows into the bales." Recalling my previous patient with the altered whistle, I diagnosed tetanus and arranged her urgent transfer to a consultant at Sydney Hospital (Sir Kenneth Noad). Indeed, she did have tetanus, and developed laryngeal spasm requiring emergency tracheotomy and 2.5 weeks in a respirator. Sir Kenneth later thanked me for saving the patient's life.

The alteration of a person's whistle in tetanus can be explained as an early effect of the increased tone in facial muscles, which causes the classic risus sardonius. As tetanus toxin must travel from peripheral nerve terminals to the nerve-cell body in the brainstem or spinal cord to exert its effects, muscles of the jaw, face and head, with their shorter axonal pathways, are often involved before those of the trunk and extremities.¹

1. Braunwald E, Hauser SL, Fauci AS, et al, editors. Harrison's principles of internal medicine. 15th ed. New York: McGraw-Hill, 2001. □

Anchoring an anaesthetist

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TO THE EDITOR: In general, it is unwise for the medical practitioner to stray from those fields in which he or she is trained. To illustrate this point, I report the case of an anaesthetist (me) caring for a patient undergoing general anaesthesia for open repair of a fractured ankle.

The operation was nearly over. The ankle had been repaired and the theatre nurse left the scene to assemble the materials needed for a leg cast. The patient was breathing spontaneously via a laryngeal mask airway. Before wound closure, the orthopaedic surgeon requested intraoperative radiography.

A large X-ray machine was wheeled into the theatre, and the radiographer positioned it over the patient, took several images and then left to process the films.

The surgeon wanted to resume surgery immediately, but who was going to remove the unattended x-ray machine, still poised directly over the operative field? I volunteered.

I hit a button on the panel. It manifested as the command for "reverse": accordingly, the machine backed itself into the wall of the operating theatre, trapping me in between.

www.toxinology.com

The Clinical Toxinology Resources website is now available at www.toxinology.com. It is a vast and growing searchable database, including 6000 images, designed to meet the needs of anyone seeking information on venomous and poisonous organisms throughout the world. Coverage is currently most complete for venomous snakes (over 800 species records); important spiders, scorpions, and marine organisms are detailed, and new records are being added weekly. In the next few months, nearly 2500 poisonous plant records will be added, along with records of poisonous mushrooms. There is also a list of antivenoms and antivenom producers worldwide. The recently updated *CSL antivenom handbook* is available in its entirety; further toxinology resource documents will be added in the future.

Access to the site is at two levels: a free general level or a more detailed subscription-based level aimed at health professionals. Subscribers can also log new cases using a secure system.

The site was developed by the Toxinology Department of the Women's and Children's Hospital, Adelaide, and the Department of Paediatrics at the University of Adelaide, with the assistance of a small grant and the goodwill and time of a number of experts from Australia and overseas. Subscriptions will be used to help meet the considerable costs of maintaining and extending the site. *MJA* readers are cordially invited to visit the site and to consider supporting this endeavour by subscribing.

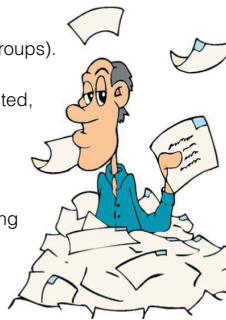
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Correspondence received in four weeks

- 814 emails (62 individually addressed; 752 undirected from various mail groups).
- 451 individual pathology results downloaded by computer.
- 181 letters (147 individually addressed; 76 standard-sized letters, undirected, from various organisations; 58 oversized letters, undirected, from various organisations).
- 8 journals (4 subscribed; 4 unsubscribed).
- 8 broadsheets.
- 8 items of other mail, including books and packages of documents, weighing a total of about 3 kg.
- 112 faxes.

Grand total: 1574 individual pieces of communication per month



At the same instant, a loud noise — consistent with partial upper airway obstruction — emanated from the anaesthetised patient. I had to free myself from my captor. Immediately.

My release strategy incorporated pressing most of the buttons on the x-ray machine in a random manner. As all were imprinted with unrecognisable symbols, this seemed a reasonable, and eventually effective (if not a recommended), method for determining the “forward” function.

I quickly returned to the patient’s head and managed the airway problem. Thankfully, the patient’s oxygen saturation did not decrease and the remainder of the anaesthetic was uneventful (the x-ray machine having been escorted out of the theatre by the radiographer on his welcome return).

Although I had been willing and, in fact, keen to expedite the surgical procedure, I suggest that doctors avoid the lure of driving foreign vehicles (they can be savage beasts). □

Communication overload

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TO THE EDITOR: In 1995 and 1998 I was fortunate enough to have extended leave of several weeks. On both occasions, when I averaged out the weight of mail, excluding newspapers, waiting for me on my return, it came to about 7 kg per month.

I wanted to determine the volume of communication I received in 2002, but:

- a substantial amount of my mail is now electronic;
- I no longer have extended holidays;
- mail cannot be now left unopened and unattended. It is opened by a trusted colleague, scanned into our patients’ medical records and the originals left out for me to see on my return;

- being away would lead to a decrease in the mail I received;
- weighing individual mail articles would be a tedious test of sanity.

So, I logged my mail for four weeks from 13 July until 9 July 2002. I have included neither mail addressed to me at home (which is now minimal and consists mainly of household bills and private correspondence) nor newspapers. A summary is shown in the Box; I have the individual log if anyone is interested.

So, how to measure the communication load of a general practitioner? I have weighed it and counted it, but it was not practical to determine how long it took to read. This is because reading it necessitates acting on it, whether this means writing a reply, incorporating it into a patient’s history or recalling a patient to order further tests.

This communication load on GPs is significant and is a further indication of the complexity of our discipline.

The weight of this load has significance for those wishing to communicate with GPs. Anything longer than a page runs a risk of joining the rapidly enlarging pile next to the GP’s desk of material that must be read at the first opportunity. Anything else is condemned to the round filing receptacle under the desk. □

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The Medical Journal of Australia (MJA) is published on the 1st and 3rd Monday of each month by the Australasian Medical Publishing Company Proprietary Limited, Level 2, 26-32 Pyrmont Bridge Rd, Pyrmont, NSW 2009. ABN 20 000 005 854. Telephone: (02) 9562 6666. Fax: (02) 9562 6699. E-mail: ampc@ampco.com.au. The Journal is printed by Offset Alpine Printing Ltd, 42 Boorea St, Lidcombe, NSW 2141.

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Published in 2 volumes per year.

Annual Subscription Rates for 2002 (Payable in Advance) to: AMPCo, Locked Bag 3030, Strawberry Hills, NSW 2012

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27,787 circulation as at
30 September, 2002



ISSN 0025-729X