Clinical implications

- Computed tomography is recommended as part of the diagnostic investigation for adults with a first generalised epileptic seizure
- Data on the effectiveness of such a strategy in identifying patients with treatable lesions are conflicting
- This study of 119 patients with a first seizure showed that computed tomography had a high diagnostic yield
- Patients without neurological symptoms and who did not misuse alcohol did not have focal lesions on computed tomography
- Routine tomography should be performed in most patients but may be unnecessary in those with uncomplicated seizures related to withdrawal of alcohol

CONCLUSION

Both the diagnostic yield and the resulting interventions justify computed tomography of the brain in most adult patients in casualty departments who have had a first generalised seizure. However, in patients who have uncomplicated seizures related to withdrawal from alcohol—suggested by two or more “yes” answers to the four CAGE questions and by the absence of focal neurological symptoms on clinical examination—computed tomography may not be mandatory, which would thus greatly reduce the number of scans that yield no positive diagnosis.

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Managing injuries from sharp instruments in health care workers in Mersey

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Exposure of health care workers to bloodborne viruses due to injuries from sharp instruments is of increasing concern. Guidelines exist on the action to be taken if a needlestick accident occurs.^{1,2} We carried out a postal questionnaire survey to investigate the management of such accidents in Mersey Regional Health Authority.

Methods and results

We sent questionnaires to all the consultant microbiologists (17), senior sisters or managers of occupational health departments (14), genitourinary physicians (nine), infectious disease physicians (two), and heads of accident and emergency departments (15) in the Mersey region. We also sent questionnaires to eight of all 12 infection control nurses.

Forty seven (72%) of the 65 questionnaires were returned. The response rate from the occupational groups ranged from 55% to 100%. In answer to the first question, nine of the respondents said that they always referred people injured by sharp instruments to another department so these respondents did not complete the rest of the questionnaire. Not all of the

remaining 38 respondents answered all the questions.

Of the 23 hospitals from which replies were received, 21 had a written policy on injuries from sharp instruments. Three hospitals did not keep records of such incidents. The responses from eight hospitals allowed us to compare the action taken by different respondents in the same hospital. In five of these hospitals the recommended action varied among respondents while in the remaining three hospitals similar management was recommended by all the respondents.

Testing of the donor (patient whose blood or other fluid is on the sharp instrument causing the injury) varied among respondents (table). Most respondents (28 out of 36) recommended long term storage of the serum of the recipient (person injured by the sharp instrument); 11 of these would test for hepatitis B surface antigen before storage. Thirty two respondents reported that they would advise recipients who were not immune to hepatitis B virus to be given hepatitis B specific immunoglobulin if (a) the donor was hepatitis B positive (26), (b) was regarded as high risk (16), or (c) was unknown (four). Thirty two respondents would

Responses to survey in Mersey Regional Health Authority about testing donor for hepatitis B surface antigen and HIV antibody after injury to member of staff from sharp instrument. Values are numbers of respondents (n=34)

	Hepatitis B surface antigen	HIV antibody
Always test	19	6
Test only high risk donor	13	19
Never test	2	9

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offer hepatitis B vaccine to (a) all non-immune recipients (24) or (b) staff in certain occupational groups only (six) or only if the donor was hepatitis B positive (two). Twenty nine out of 32 respondents would seek advice about zidovudine if a donor was known to be HIV positive. None of the hospitals' policies outlined procedures for dealing with a risk of transmission of hepatitis C virus.

Comment

As the overall response rate was only 72% we could not assess how well the results reflect procedures throughout the Mersey region. Some important points, however, came out of the survey.

We found that the screening of donors varied depending on the person handling the incident. Storage of serum from the recipient was usually recommended, however, and over a third of respondents who recommended storage also tested the samples for hepatitis B surface antigen. The result of such testing only provides information about previous exposure; it does not show infection as a result of the current injury.

It is of concern that immunisation against hepatitis B virus may be advised only for staff who are in occupations that are regarded as high risk, as surveys have shown that staff in a wide range of occupations are vulnerable to injury.³ We also found that the criteria

for using hepatitis B immunoglobulin varied among respondents.

None of the hospitals' policies on injuries from sharp instruments addressed the issues that would arise if transmission of hepatitis C virus was a risk. Seroconversion occurs in 2.7% of cases of exposure to blood from people who are positive for hepatitis C antibodies, and up to 50% of those who seroconvert may develop irreversible liver disease.^{4,5}

In conclusion, we have shown that the management of injuries from sharp instruments varied both among hospitals and among members of staff in the same hospital. It is important to reduce the number of needlestick accidents, but as preventive measures do not always succeed health care workers who are injured by a sharp instrument must be able to obtain clear advice and counselling immediately, with appropriate intervention and follow up.

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Commercial source of drug information: comparison between the United Kingdom and India

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The prescription of proprietary drugs and the lack of an independent formulary may contribute to the use of a commercial source of drug information by doctors. The *Monthly Index of Medical Specialties (MIMS)* is one such publication available in both the United Kingdom and India. We compared the two editions for differences in the information provided and the quality of advertisements.

Methods and results

We analysed the March 1992 issue of the British edition of *MIMS* and the August 1993 issue of the Indian edition, for several general features (see table). We recorded the numbers of advertisements, products under each heading and on each page, and words used to describe a product. Full page advertisements were studied in detail as described previously.¹ Briefly, information provided, drug names, and the use of superlatives and visual images were recorded.

The general features of both editions were similar (table). The initial description of a drug group focused mainly on the indications and adverse drug reactions. The quality of the information given varied from group to group, differing inconsistently between the two editions. Product information gave the trade and generic names, manufacturer, preparation(s), dosage, and cost, with just the numbers of indications and side effects. Product appearance and its legal category were given in the British but not the Indian edition. Therapeutic comparisons between the drugs and drug groups were never given, and the information provided was generally insufficiently detailed in both editions.

Legibility was poor in the Indian *MIMS*. Twenty three tables and charts were given in the British *MIMS* but none was given in the Indian version. Some peculiar headings appeared in both editions (cerebral activators, enzymes-digestives, respiratory stimulants in the Indian *MIMS*; wart removers, leg ulcer treatments in the British version). The table shows important differences in the number of products listed under many therapeutic headings.

Indications and side effects were omitted in 51% and 86% of advertisements respectively in the Indian edition and in 59% and 57% respectively in the British

Summary of comparison between British and Indian editions of "MIMS"

	British MIMS	Indian MIMS
<i>General features</i>		
Price per issue	£5 approx	27 Rupees (£0.6)
Printing area (mm)	195 × 132	200 × 115
No of pages	328	284
No (%) of pages lost in advertisements	68 (21)	66 (23)
No of headings	84	91
No of listed products (preparations)	2315 (3295)	1973 (2905)
No of products described per page*	9 (7-12)	10 (8-12)
No of words per entry*	53 (35-73)	51 (38-72)
No of products (preparations) listed under various headings:		
Laxatives, etc	41 (50)	15 (18)
Antidiarrhoeals	13 (17)	31 (43)
Enzymes-digestives	0	22 (30)
NSAIDs	44 (69)	72 (114)
Contraceptives	53 (64)	7 (7)
Anti-infectives	111 (209)	198 (427)
Tonics and vitamins	36 (54)	118 (165)
Cough remedies	26 (51)	59 (77)
Acne treatment	37 (55)	4 (5)
Skin preparations	95 (124)	22 (28)
Dressings and appliances	157 (166)	10 (14)
<i>Advertisements</i>		
Total No	114	80
No (%):		
Full page	37 (32)	57 (71)
With generic name missing	3 (8)	11 (19)
With trade name:		
> Five times size of generic name	22 (65)	23 (51)
In colour	27 (73)	36 (64)
With generic name in colour	2 (6)	5 (11)
Using images	35 (95)	50 (88)

*Median value (interquartile range).
NSAIDs = non-steroidal anti-inflammatory drugs.

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