Comment

Our study confirms previous reports that albumin causes negligible natriuresis in patients with strong sodium retention.¹ Frusemide in sufficient dosage proved strongly natriuretic but we could not establish any potentiation of the frusemide effect by infusion of albumin. Only two studies have claimed a synergistic effect of combined albumin and frusemide, but both were retrospective and did not compare the effects of frusemide alone with those of combined frusemide and albumin in the same patients.^{2,3} Our study is the first to do so under controlled conditions. Albumin inside the renal tubules has been shown to bind frusemide and thus blunt its diuretic action.⁴ The increase in tubular albumin that occurs after infusion of albumin may

have exerted some inhibitory action in our subjects, although because we applied a maximally effective dose such an effect is less likely. Our results do not support the use of albumin in the treatment of patients with the nephrotic syndrome.

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Parents in the recovery room: survey of parental and staff attitudes

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It is unusual in British hospitals for parents to be with their child while recovering from anaesthesia, although their presence during induction of anaesthesia is now common. Parents are encouraged to be with their child in other clinical areas,¹ and American experience suggests many parents value being present in the recovery room.² Before introducing this practice in our hospital we sought to determine the attitudes of parents and staff to parental presence during recovery from anaesthesia.

Subjects, methods, and results

We invited the parents of 150 consecutive children presenting for elective surgery to come to the recovery room as their child emerged from anaesthesia. Recovery staff decided when to call the parent, with the guide-

lines that the child should be awakening, maintaining his or her airway unsupported, and cardiovascularly stable, although not yet fully conscious. Parents completed one questionnaire before coming to the anaesthetic room and another on leaving the recovery area. Recovery staff completed a questionnaire after the family had left. Questions were asked as statements and responses indicated as strongly agree, agree, disagree, or strongly disagree. The study was approved by our ethics committee and parents gave informed consent.

The table gives the results. Only three parents initially did not want to accompany their child to the recovery room, although one mother changed her mind. A further 10 had left the ward to find refreshments when they were called to the recovery room and so were unable to attend.

After initial reservations, recovery staff felt that parental presence was worth while. Their attitude became more positive as the trial progressed; parental presence was judged a success in 29 (58%) of the first 50 cases but this increased to 49 (98%) of the last 50 cases, despite some parents who were distracting and "got in the way."

Comment

Despite some anxieties parents wanted to be with their child during recovery from anaesthesia and surgery. Most felt that they could help and comfort their child. We do not know, however, if parental presence during recovery reduces children's stress in a similar way to that shown during induction of anaesthesia.³

Staff quickly learnt to cope with parents as observers. The worries of clinical staff about parents witnessing serious postoperative complications (for example, airway obstruction, haemorrhage) were unfounded. It is usually possible to predict which children are likely to have difficulties postoperatively, and parents were not summoned until the child's airway was secure. No parent was asked to leave the recovery room unexpectedly. Indeed, one parent was able to reassure a recovery nurse, telling her that "the bleeding was much worse last time."

While a child is in hospital parents should not be considered as visitors and should be encouraged at all times to offer care and support for their child, unless the interests of the child preclude this.⁴ We believe that parents should be present during emergence from anaesthesia whenever possible. Unwilling parents, however, should not be pressurised. Bevan *et al* have shown that high anxiety levels in parents are associated with more behavioural disturbances in children.⁵ A similar pattern would be expected in the recovery room.

Responses of parents and nurses to questionnaires on parental attendance at recovery room

	Strongly agree/ agree	Strongly disagree/ disagree
Preoperative parental questionnaire (144 returned):		
You would accompany your child to the anaesthetic room	142	1
You would like to accompany your child to the recovery room	141	3
Your presence will be helpful to your child in the recovery room	143	1
You will be able to comfort your child in the recovery room	143	0
You will be in the way in the recovery room	9	133
You find it difficult to cope with the thought that your child might be distressed or in pain after the operation	67	76
You are frightened by the thought of going to the recovery room	20	122
You are worried that you might see an operation taking place	12	132
You are worried that you might feel unwell	15	127
The nursing staff want you to accompany your child	126	15
The doctors want you to accompany your child	124	16
Postoperative parental questionnaire (132 returned, 132 parents attended):		
Your presence was helpful to your child in the anaesthetic room	132	0
Your presence was helpful to your child in the recovery room	130	2
You were able to comfort your child in the recovery room	129	3
You got in the way in the anaesthetic room	2	130
You got in the way in the recovery room	4	128
You found the recovery room frightening	7	125
The recovery room made you feel anxious	23	109
The recovery room made you feel unwell	5	127
If your child had another operation you would choose to go to the recovery room with him/her	130	2
Nursing questionnaire (132 returned):		
The parent's presence was helpful to you in recovery	103	27
The parent's presence was helpful to the child in recovery	104	25
The parent appeared to be comfortable in recovery	110	21
The parent looked distressed to be in recovery	19	113
The parent got in the way in recovery	10	121
You were distracted from your work by the parent's presence	24	107
You felt you were looking after "two" patients, ie, parent and child	31	101
You would like parental presence in recovery to become a permanent arrangement	80	41

Some practical problems exist, however, ranging from the provision of extra chairs to the need for a liaison nurse to escort parents to and from the recovery room. Few operating suites have waiting areas for relatives, and ward areas are often inadequate. In summary, parents welcomed the opportunity to come to the recovery room at an early stage, few problems occurred, and there was staff support for continuing the practice.

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Why patients choose paracetamol for self poisoning and their knowledge of its dangers

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Details of 80 subjects with self poisoning by paracetamol, their reasons for choosing paracetamol, and effects they thought could result from paracetamol overdose

	No of subjects
Sex:	
Female	53
Male	27
Age (years):	
13-20	32
21-35	32
≥36	16
Reasons for choosing paracetamol*:	
Available	50
Dangerous	29
Cheap	4
Subject was uncertain	3
Anticipated effects of paracetamol overdose*:	
Completely safe	0
Mild, short lived effects	2
Harmful but short lasting effects	8
Permanent damage or harm	16
Could cause death	62
Not known	6

*More than one option could be chosen.

Paracetamol is the most commonly used substance in deliberate self poisoning.¹ As a result, hepatic toxicity due to paracetamol accounts for over half of all cases referred to liver units because of fulminant liver failure,² is the definite cause of at least 150 deaths a year in the United Kingdom³ and is now an important reason for liver transplantation.⁴

The reasons why people choose paracetamol for self poisoning and their understanding of its effects have been little studied. Nearly 20 years ago a study of patients with self poisoning by paracetamol admitted to London's King's College Hospital—a tertiary referral centre for patients with liver problems—showed that most patients did not know that paracetamol was dangerous in overdose.⁵ That study was conducted when self poisoning with paracetamol was much less common than it is now and before there had been much publicity about the phenomenon. We conducted the present study to determine why current patients with self poisoning by paracetamol choose paracetamol and their awareness of its dangers.

Subjects, methods, and results

In all, 80 patients out of a consecutive sample of 123 patients with self poisoning who were admitted to the John Radcliffe Hospital, Oxford, from September 1992 to March 1993 having taken overdoses of paracetamol or compounds containing paracetamol or both, consented to participate in the research interview. The subjects comprised more females than males, and most were fairly young (table). Of the remaining 43 patients, 18 refused to participate, 20 had left hospital before their consent could be obtained, and five were not invited because they were confused or too ill. No significant differences existed between the included and excluded patients according to sex and age. The interviewers were all experienced in interviewing patients with self poisoning. The interview was based on a structured questionnaire.

Availability was the most common reason for subjects choosing paracetamol for their overdoses, although more than a third said they chose it because they knew it was dangerous (table). Although 38 subjects had taken an overdose with paracetamol that they had obtained for medical purposes, 42 had obtained the drug specifically for an overdose. When

the subjects were asked to choose which of six possible outcomes of a paracetamol overdose they had expected, few thought that an overdose was safe, and more than three quarters thought that it could cause death. Thirty four subjects knew that paracetamol could cause damage to or failure of the liver. Most subjects, however, said that they thought that any harmful effects would have shown fairly quickly; only 18 realised that the effects would take more than 24 hours to appear. Responses to an open question about the specific effects of paracetamol showed that 42 subjects had expected paracetamol to cause unconsciousness.

Comment

The fact that paracetamol is dangerous in overdose seemed well recognised among our subjects, in contrast with the findings of the earlier study at King's College Hospital.⁵ This difference presumably reflects extensive media information about self poisoning with paracetamol and awareness of deaths resulting from overdose. Our study showed, however, a lack of knowledge about the specific effects that an overdose might have and the timing of such effects.

Prevention of fatal self poisoning with paracetamol is now an urgent issue. While education about the potential effects might be one approach, the considerable awareness of the dangers had clearly not put our subjects off. Reducing the number of tablets in individual preparations (with only one preparation allowed per purchase) seems to be a potentially more useful step.

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Correction

Knowledge and experience of young people regarding drug misuse, 1969-94

A printer's error occurred in this paper by Dr Wright and Laurence Pearl (7 January, pp 20-4). The legend to the first figure should have read: "FIG 1—Percentages (numbers) of pupils who mentioned each drug when asked 'What drugs taken by addicts do you know?'"