In the hope of avoiding such pitfalls and to focus the doctor's mind both on a systematic approach to the secondary survey and the subsequent management priorities, a simple aide memoire in the style of ATLS teaching is proposed (table 1). The secondary survey includes the "AMPLE" history.

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Levofloxacin induced myasthenia crisis

Patients with myasthenia gravis (MG) may suffer a worsening of symptoms upon exposure to a variety of medications. The relationship between MG and medication effects is complex. Some medications (such as penicillamine and α -interferon) appear to cause MG occasionally, while other drugs (such as aminoglycoside antibiotics and quinine) may lead to MG symptoms by simply unmasking a pre-existing mild case. In patients with known MG, there is a long list of drugs that are reported to be associated with increased weakness.¹ Myasthenic crisis is a life threatening situation in which the weakness arising from MG is severe enough to cause respiratory failure necessitating intubation.² This case report describes the development of myasthenic crisis and respiratory depression following the use of levofloxacin in a patient with no previous diagnosis of MG.

A 45 year old male patient was diagnosed with atypical pneumonia at the emergency department (ED) to which he presented with a complaint of coughing and expectoration, and was given a prescription for levofloxacin. He re-presented with severe respiratory difficulty 36 hours after commencing the medication. He was attached to a mechanical ventilator and intubated in the ED with a diagnosis of severe respiratory insufficiency. With the patient's tensilon test result proving positive and a decremental response shown on electromyogram, he was diagnosed with MG. Thymoma was determined using computed tomography, and thymectomy performed. Pridostigmine and steroid treatment was initiated. He was removed from the ventilator on the third day and discharged in a healthy condition on the 10th day.

Fluoroquinolones are widely used antibiotics, and have relatively few side effects. The most common adverse reactions are nausea, abdominal discomfort, headache, and dizziness. Rarely, hallucinations, delirium, and seizures have occurred. There are reports of the exacerbation of MG by ciprofloxacin, norfloxacin, and penfloxacin, ofloxacin, and trovafloxacin.^{3,4} The occurrence of increased myasthenic weakness shortly after the start of fluoroquinolone treatment and the rapid improvement after withdrawal of the antibiotic in each reported case are consistent with a fluoroquinolone block of neuromuscular transmission.

Fluoroquinolones reduce the amplitude of the miniature endplate potentials.⁴

Although similar effects of fluoroquinolones have been reported previously, no case involving levofloxacin, which is prescribed on a widespread basis, has been reported. This case shows that, like other quinolones, levofloxacin may also have a symptom triggering effect in subclinical MG and may even lead to myasthenic crises.

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Could lack of necessary equipment and training to manage common paediatric emergencies within primary healthcare centres impact on secondary healthcare services?

Front line paramedics in the UK lack emergency paediatric equipment and skills.¹ However, comparative assessments within primary healthcare centres have not been forthcoming, despite their potential propensity for paediatric emergencies and need for resuscitation drugs.² Indeed, within our locality, East Midlands ambulances were summoned to 27 paediatric emergencies in the same centres surveyed in the preceding year. Moreover, in over 90% of cases paramedics needed to instigate further treatment, primarily for paediatric airway and breathing emergencies, including suspected anaphylaxis, asthma, croup, and pneumonia.

We ascertained the availability and accessibility of basic equipment for managing the paediatric airway and breathing, circulation, and potential drugs for common paediatric emergencies, using an e-mail questionnaire to all 27 primary health care centres within the Nottingham city region. Within practices, children aged 0-16 years comprised a median 25.5% of the total patient number (median 4600, range 1560 to 12 093). No practice had all 21 basic resuscitation items, with 59% of practices having ≤ 10 of these items. Indeed, 52% of practices had ≤ 4 basic airway and breathing items, 82% of practices had ≤ 4

basic circulatory items, and 85% of practices had ≤ 4 basic drug items. Only two practices had external defibrillators with paediatric paddles, and only one practice had a pulse oximeter. Only 30% of practices had algorithms for basic life support and common emergencies, and kept their equipment together. Only 17.5% of GPs had been trained in paediatric resuscitation in the past 5 years.

In conclusion, we have shown that primary healthcare centres lack the basic resuscitation equipment and skills to manage common paediatric emergencies. In order to improve the preparedness of these centres, we need to: (a) standardise locally available basic resuscitation equipment, (b) assess and train all necessary personnel, and (c) ascertain the occurrence of critical incidents through a local and national database.

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BOOK REVIEW

Cope's early diagnosis of the acute abdomen, 21st ed

Z Cope, revised by W Silen. Oxford: Oxford University Press, 2005, £35.99. ISBN 0-19-517546-8

This classic textbook was first published in 1921. It comes around as regularly as the Olympic Games and as reliably as the full moon.

Why is it so good? Its emphasis is on clinical and not laboratory or radiological diagnosis and it does not rely on algorithms, protocols, pathways, or a plethora of long lists to memorise. Its style initially seems old fashioned, and to many eyes it may seem turgid; however, if you stick with it, it grows on you. It becomes very readable.

In our specialty, which tends towards a "rule out" approach to diagnosis and assessment, many will think this book has no place. Nothing can be further from the truth. It should be required reading for all trainees. Consultants who have not read it before will also learn from it.

Including the index, it is 298 pages long. Although the line drawings (which are plentiful) are fine, the radiological illustrations are nothing to write home about. It doesn't matter. It's all in the history and examination, not the investigations. Read it.

G Hughes