concluded cyclizine may be useful if avoidance or prompt reversal of the hypotensive effect of opiate is required.³ It is also relevant to observe that no data were given for simultaneous administration of cyclizine with opiate, because cyclizine is usually administered simultaneously with opiate, considerable caution is required if the conclusions of this study are to be translated into advice about clinical care.

The clinical bottom line begs the question "if not cyclizine, what should I use?" We repeated their search strategy but replaced the "cyclizine" with "metoclopramide" or "stemetil/prochlorperazine", revealing no studies of the effects of these two commonly used drugs. A Cochrane study is being undertaken to review other anti-emetics,⁴ we suggest that a more appropriate conclusion would be "There is the possibility of adverse haemodynamic effects of cyclizine in patients with heart failure, and of beneficial effects in patients with opiate induced hypotension; the effects of other known anti-emetics are unknown."

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Pacing in hypothermia: does it work?

Hypothermia is a relatively common clinical problem in the emergency department. It requires a informed response as regards the physiological changes that occur when there is a significant drop in core body temperature.

We describe the case of an elderly man who appeared particularly resistant.

An 87 year old man was found collapsed outdoors in his coal shed having been there most of the night. On presentation to the emergency department he did not have an oral airway adjunct, oxygen saturations were 82% on 100% oxygen, BP was 65/50, and pulse rate was 64 bpm. In addition, the patient had undetectable peripheral pulses and a GCS of 7 (E1 M4 V2). Core temperature was 24.1°C. Past medical history included depression, hypothyroidism, and a permanent pacemaker inserted for complete heart block. A diagnosis of severe hypothermia was made and rewarming was initiated using standard passive and active techniques, although no invasive measures were used

and the patient was not intubated. The initial ECG showed a paced rhythm of 60 bpm with normal complexes and throughout the rewarming period this was consistent with no arrhythmias of any sort recorded. Despite the need for a small amount of noradrenaline, cardiac rhythm remained constant and the patient made an uneventful recovery to discharge.

Cardiac arrhythmias and ECG changes are common in hypothermia with the incidence increasing as core body temperature decreases.¹ ECG changes include prolongation of the PR, QRS, and QT intervals and the appearance of pathognomonic J waves, while arrhythmias commonly described include bradycardias, atrial fibrillation, and ventricular tachyarrhythmias.² Despite the presence of severe hypothermia in this case, the ECG remained consistently normal and we postulate that this was in fact due to the presence of the internal cardiac pacemaker. Previous reports have suggested that the severely hypothermic heart is unresponsive to pacemaker stimulation, but this case suggests otherwise.³

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Use of a screwdriver in the emergency department

A 23 year old male attended our department with a history of accidental injury to his left index finger. While attempting to attach a metal screw to a wall using a powered electric screw gun, the patient pierced his finger with a 3.5 cm screw. The point of entry was the extensor aspect of the distal third of the left index finger and the exit was on the flexor aspect of the middle third of the finger (fig 1).

Figure 1 Screw through patient's finger (informed consent was obtained for publication of this figure).

No fracture was seen on x ray.

Local anaesthesia was achieved using a ring block to the finger. An attempt was made to remove the metal screw using traction with a pair of Spencer-Wells forceps. However, this was unsuccessful and we anticipated extensive tissue damage if more force was used. We therefore located a Philips screwdriver (fig 2) from the works department and used this to remove the metal screw. The screw came out easily, with minimum effort and little collateral tissue damage. The patient was reviewed 3 days later and had an uneventful recovery.

This case shows the importance of keeping simple mechanical tools in the emergency department (for example, screwdrivers and wire cutters) along with more conventional surgical instruments. The mechanism of injury gave us the idea to remove the screw using a screwdriver; this approach was nearly effortless and minimised associated tissue damage.

A Medline search did not produce any references where a screwdriver had been used to remove a foreign body in the emergency department. Although we would be surprised if this is the first time that this has occurred, we believe that this is the first time it has been written up.

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Figure 2 Screwdriver used to remove screw.