Table 1 Recorded injuries

Fractured hips	3
Facial fractures	2
Facial soft tissue injuries needing treatment	3
Shoulder dislocation and swollen knee	1
Fracture wrist/hand	2
Minor soft tissue injuries	4

patients (9.2%) cited storm wind as being a contributory factor for their attendance. Nine of these patients were women and 10 were over the age of 60 years. Table 1 lists the recorded injuries.

Although the overall attendance over the 24 h period was not increased, there was an unusually high activity for the same 6 h time frame in the accident and emergency department. Nine per cent of the patients seen were wind related injuries with some patients presenting with more than one injury. Seven of the 11 patients required inpatient management. We are aware of two other fractures that required inpatient surgical treatment that presented outside our time frame.

These figures highlight the true human cost of "wind damage" in an area of north west London. The economic cost of seven additional surgical admissions in this small patch of the country may have been mirrored all over the country. Although the Department of Health does provide London with emergency planning weather, environmental and temperature warnings, our data suggest that early weather warnings by the Met Office may need to be directed at high risk groups, notably elderly women.

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Oral N-acetylcysteine for acute paracetamol poisoning

In the UK, a 20 h intravenous N-acetylcysteine (NAC) regimen is the standard antidote for significant acute paracetamol poisoning. In the USA, although the Food and Drug Administration approved the use of an intravenous formulation of NAC in 2004, a 72 h oral NAC protocol is still standard practice.¹ If the US experience demonstrates that oral NAC is safe and effective, then it might be reasonable occasionally to use it in the UK—for example, in cases of difficult or refused intravenous access.

A national email survey of all 64 emergency medicine consultants and registrars in Wales

was performed to determine attitudes to the use of oral NAC. After a further email reminder a total of 51/64 had replied, a response rate of 80%. Only 29/51 (57%) knew about oral NAC, and only 2/51 (4%) had used it (both in the USA). Having been made aware of it, 36/51 (71%) would consider using it, particularly for cases of difficult intravenous access or needle phobia, providing there was evidence for its safety and efficacy, and it was available.

Oral NAC is available in the UK on a named patient basis, and the standard intravenous preparation can be drunk through a straw (preferably disguised in cola or juice).

No randomised controlled trial has been performed to compare oral and intravenous NAC. The 2006 Cochrane review of several case series concluded there was no clear difference in efficacy (in terms of hepatotoxicity and mortality rates) between intravenous and oral routes. No studies have demonstrated any difference in safety or side effects.²

Oral NAC has been used for 30 years in the USA with similar efficacy and safety as in the UK with intravenous NAC. This survey suggests that UK emergency physicians might welcome the option to use oral NAC in certain limited circumstances, if it were more readily available.

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BOOK REVIEWS

Developing the wise doctor: a resource for trainers and trainees in the MMC

Edited by Della Fish, Linda de Cossart. Published by The Royal Society of Medicine Press, 2007. ISBN 13 978-1-85315-618-2

Flattened by MMC? This book will resuscitate you whether trainer or trainee.

Faced with a new model of training I am uncertain as to how to best help trainees, uncomfortable with some of the underlying logic of MMC with its emphasis on assessment, progression, limited time, early career decisions... and a sense that something important is missing. This book helped me, confirmed that I wasn't losing it, that the things I think are important others do as well, and that these important things are not expressed easily and are difficult to grapple with but no less important for this.

This book reaffirms what it is to be a doctor in the face of the techno-rational approach that sees doctors as technicians whose education is divisible into small assessable chunks.

The first part of the book critiques present postgraduate medical education and identifies those things you know are important but difficult to describe and teach. Specifically the significance of context, the professional values the doctor subscribes to, different kinds of knowledge, clinical thinking, professional judgement and the therapeutic relationship. The second part sets about helping you get these things that you acquired by osmosis, haphazardly, unknowingly over a long time. Future trainees need to get to the end point faster and more efficiently than their trainers. The sections are easy to follow with a similar format, a scenario, an important principle, a heuristic (short cut, rule of thumb) principle, resources that explain the principle, how it can be used, and a conclusion to the opening scenario.

In an age of pressure to reach targets, with increased government surveillance of the medical profession, this book will come as a breath of fresh air and perhaps provide a roadmap that leads to re-establishing what is important in medicine.

At the end of this you will feel refreshed that all is not lost and that there are ways to teach those things that are difficult to make tangible.

M J Clancy

Core topics in airway management

Edited by Ian Calder, Adrian Pearce. Cambridge University Press, 2005, £35 (hardback). ISBN 1-841-10158-3

There is a clear and increasing awareness of the importance of airway management for emergency medicine doctors. Does this book contribute to the knowledge base required to practise this skill in emergency medicine?

The editors and their 18 contributing authors are all consultant anaesthetists, and their book is not surprisingly targeted at the anaesthesia/intensive medicine section of the market, although emergency medicine is mentioned in the preface. Sadly this is the only time that emergency medicine is acknowledged. There are sections of generic value (for example, the anatomy and physiology chapters) which are well-written, although the style could best be described as quirky—the anatomy chapter opens with "Fine lingerie itself is rather tedious: it is the context that makes it exciting". From this intriguing start, this particular chapter gives an excellent (and entertaining) description of the functional anatomy involved. The remainder of the book, however, does not gel effectively, and rather than a cohesive textbook you get the impression of a series of somewhat unrelated essays—for example, the properties of six different types of laser tubes are detailed in one chapter, but there is no chapter on failed intubation.

There are many suggestions throughout the book which indicate that the individual authors are imparting valuable tricks of the trade, not to be found in more academic texts, and this is one of the book's strengths. From an emergency medicine point of view, however, a major deficit is that there is no section on decision making regarding the need to definitively manage an airway, which seems to me to be the most core