

HANDBOOK OF ACUTE MEDICINE

5th Edition

eds. PH Feng, KM Fock, P Eng

Singapore: APAC Publishers, 1992

This *Handbook* is familiar to many doctors and students. The editors have indexed its 120 pages, a boon to users. The booklet encapsulates an approach to the 'blood and guts' of acute and emergency disease, the accelerated breakdown of systemic order. I enjoyed the chapters on cardiac emergencies and arrhythmias, which follow closely Anglo-American authorities. I also liked the chapters on neurological emergencies, anaphylaxis, 'autoimmune emergencies' and life-threatening infections, and the Annex.

Still, I have reservations. We should probably avoid aminophylline in pulmonary oedema, except in patients who would react badly to opioid analgesia. Why include cardiogenic shock (clinically hopeless), or the amrinone-type of inotrope (useless)? 'Allergy' should mention anaphylactoid reactions; adrenaline here should be given intramuscularly only; why give a histamine₂ blocker preventively unless glucocorticoids actually initiate peptic ulceration? The substitution of flow-charts for the sequential lists would greatly improve the *Handbook*.

What about factual errors? There are none significant: the booklet is broadly safe. Where the *Handbook* falls down is in consistency: Nor does it declare its objective clearly at the outset. The phrases 'acute medicine', 'intensive care', 'immediate care', and 'acute emergencies' are mingled throughout. In an age when sloppy (in the language sense) doctors talk about 'emergent cases', good terminology is important. By broad consensus, an 'emergency' is a problem that demands action within seconds to 5 minutes; an 'urgency' one which requires action within the first hour; 'acute illness' that which arises rapidly and probably needs hospital care. 'Intensive care' is too pretentious. Thirdly, too many of the units are non-standard (eg 'mE' for mmol). The *Système International* has long established its grip in science, healthcare, and industry. Fourthly, strange abbreviations obfuscate the reader. Nobody minds the odd 'KCl' (not recommended by the Council of Biology Editors), but 'Ca Gluconate' and 'ampl' are unacceptable. Spelling out crucial names will not significantly expand the text: legibility is cheap. Convention requires the lower case for generic (eg flumazenil) and upper case for proprietary names (eg Anexate). Finally, doses should appear as 'mass units/kg body mass' wherever sensible.

Overall, my chief concern is that, in order to be brief, the authors have been too prescriptive. This encourages action without due cerebration. For instance, 'coma' is described under 'neurological emergencies,' and hyperkalaemia, which is trickier than hypokalaemia, is described not under 'metabolic' but 'uraemic' emergencies. Can life be so simple? The usual reader is likely to be somewhat ignorant, sometimes diffident (or, much worse, arrogant), harrassed, or all three. The reader may thus apply instructions reflexly, rather than discuss The Patient

with an experienced physician. Such action may produce suboptimal, even disastrous, results for patients. We should always encourage that poorly rewarded process, thinking.

Chapter 16 on 'acute poisoning' illustrates this concern. Table 2 perpetuates the dangerous myth of the simplistic 'antidote' approach to the 'average' patient. For instance, phytomenadione (vitamin K₁); whereas 3-5 mg injected intravenously, with or without clotting factor concentrates (or fresh plasma), is appropriate for severe warfarin-induced bleeding, the simple withholding of warfarin, with or without phytomenadione 0.5-2.0 mg, may suffice for less severe bleeding. There are reports that flumazenil may cause ventricular fibrillation in the damaged heart; even the older drug naloxone may induce pressor responses and pulmonary oedema in opioid-dependent patients. A table or a list cannot convey such cautions.

Of course, there are omissions and strange inclusions. Oral adsorbents are missing from Chapter 16; these effectively unburden the blood with some common drugs. Many toxicologists propose activated charcoal early, before stomach lavage. Most now avoid forced diuresis in patients below 16 and above 60 years, especially where dialysis is practicable. Curiously, Table 1 contains bromide and glutethimide. How is 'salicylate' an antidote for anticholinergic toxicity (Table 2)? A note should warn against pralidoxime in carbamate poisoning, for which it is useless and potentially damaging.

Arguably, the learner-doctor should already know the principles enshrined in the booklet; dosages may then be found in the *British National Formulary (BNF)* or drug package inserts. Evidently the *BNF* cannot satisfy everyone, but it excels in the drug treatment of acute clinical problems. In general, learners should first consult their mentors and then perhaps a larger text, like the *Oxford Handbook of Clinical Medicine*. They should then tailor their actions to the individual patient.

Is there a place for the present booklet? Although the *Oxford Handbook*, for instance, costs only \$34.00, at 380 grams it weighs three times more than the present *Handbook*. That some learner-doctors carry the present *Handbook* in their pockets suggests that either it is losably cheap, or it fills a niche among aide-memoires. I believe the latter, but I believe even more that "The great end of life is not knowledge but action" [Thomas Henry Huxley, 1877].

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