*Reference*

DAVID, J. & PRIOR-WILLEARD, P. F. S. (1993) Resuscitation skills of MRCP candidates. *British Medical Journal*, **306**, 1578–1579.

DEAR SIRS

I was interested to read the article concerning resuscitation skills of psychiatric trainees by Kosky and Spearpoint (*Psychiatric Bulletin*, August 1993, **17**, 489–491) and endorse their recommendation that all doctors should have refresher courses on cardiopulmonary resuscitation.

It would seem that psychiatric hospitals are running tremendous risks in the way they are equipped to deal with medical emergencies and are fortunate that this is not exposed in the mass media. The risks are not purely because of poorly trained doctors in the skills of resuscitation, but in the rapidly decreasing time psychiatric nurses spend on general hospital placements in their training, in the poverty of equipment required in a medical emergency and in the level of complacency surrounding the notion that psychiatric patients are medically fit and healthy.

I felt that the authors had set their sights far too high; certainly if I was at the scene of a cardiac arrest in a psychiatric hospital and was presented with a defibrillator and an array of anti-arrhythmic drugs I would require as much resuscitation as the patient.

As a registrar in general psychiatry I was involved in two nightmares. The first required the rapid administration of intravenous fluid; a venflon was finally located on the patient's ward, a giving set on another ward, an out-of-date bag of saline in the extra care area at the other end of the hospital and no drip stand to be found. On another occasion a patient arrested following an overdose; she was maintained with cardiopulmonary resuscitation until an ambulance arrived. However, the ambulancemen somehow assumed that the patient could be transported down a large flight of stairs, through a long corridor and down another flight of stairs in a wheelchair, when she had no cardiac output. When they returned with an appropriate stretcher one of the ambulancemen himself was suffering from a severe asthmatic attack.

Following these traumatic experiences I have learnt the cardinal rules concerning medical emergencies in psychiatric hospitals.

(a) The patient needs to be removed from a psychiatric hospital as rapidly as possible. The first thing to do before initiating any procedures is to ensure that an ambulance is on the way and is aware that it is not a call to transfer routinely a patient from one hospital to another but that there is a real emergency.

(b) Anything other than first aid is unrealistic and dangerous. For example, to give drugs during an arrest assumes that there will be a competent nurse present to continue the cardiopulmonary resuscitation.

(c) Put in writing to the management your unease about the risks being taken.

(d) Hope that it is your colleagues who are on call when the next disaster occurs.

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## *Thyroid microsomal antibody*

DEAR SIRS

The paper by Suresh & Robertson (*Psychiatric Bulletin*, August 1993, **17**, 477–478) prompts me to direct attention to thyroid microsomal antibody (TMA) concentrations, an additional component of thyroid dysfunction in the population with Down's syndrome (Kohen & Wise, 1992).

In this study of 30 randomly selected clinically euthyroid Down's syndrome subjects, TMA concentration results showed that 40% (n = 12) had positive TMA (titre > 40), of whom nine were aged under 50 and three over. Of the individuals negative for TMA, five were under 50 and 13 over ($P = 0.03$). The study concluded that this different of circulating TMA in subjects with Down's syndrome over 50 years of age could be the result of selective mortality of the younger group with positive TMA results.

Investigations of the high prevalence of thyroid dysfunction in Down's syndrome has brought great improvement to their wellbeing. The study of TMA concentration results may also bring new insight into the high rates of coronary heart disease, vascular and immunological disorders and Alzheimer's disease in this population. I believe that regular screening for thyroid dysfunction should be supplemented by TMA results to clarify this possible interaction between thyroid, immunology and pathology in the other systems of the Down's syndrome population.

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*Reference*

KOHEN, D. & WISE, P. (1992) Autoantibodies in Down's syndrome. *Lancet*, **340**, 430.

## *Second medical recommendations*

DEAR SIRS

I was interested to read the article on second medical recommendations for the Mental Health Act (Ung, *Psychiatric Bulletin*, August 1993, **17**, 466–468). This highlighted, particularly in the case of general practitioners, the lack of independence in these assessments.