Red back spider bite

Dear Editor

We recently had an interesting case of red back spider bite in a child in our rural hospital in Winton, Queensland.

The 13 month old boy was bitten at about 10.30 am while playing in a corner behind a door. His mother reported that he started to cry and was found with cobweb on his foot and a red back spider nearby (which was killed to bring in for identification). We guessed the bite may have been to the foot or hand.

The boy is well known to us and is usually placid and happy but within 30 minutes he was screaming inconsolably. The classic signs of red back bite (latrodectism) such as local erythema and local diaphoresis were absent, as is often the case in children.[1] His temperature was 37.7°C on arrival and his pulse varied between 150–180 bpm but there were no other systemic effects of note. A bite site was not evident, so we didn't know where to apply an ice pack.

Management started with a telephone call to Poisons Information (131 126 Australia wide). Oral paracetamol and naproxen was ineffective, so Poisons Information suggested oral oxycodone syrup or IVI morphine. Having no oxycodone on site, we tried a stat dose of IVI morphine at 0.05 mg/kg. The child settled into a fitful sleep, however woke soon afterward still irritable and distressed, although not as severely as upon initial presentation.

Poisons Information referred us to their on call toxicologist who suggested proceeding to IVI red back antivenom as this would be the only way to control the pain in a case where envenomation has occurred. We had one vial of red back antivenom on site. Our fears of anaphylaxis were allayed when the toxicologist reassured us that, given slowly, the incidence of anaphylaxis is low. We diluted the antivenom 1:10 and gave it slowly over 30 minutes, closely monitoring the child's blood pressure and oxygen saturation. We also drew up 1:10 000 adrenaline diluted to 10 mL to have ready for IVI administration. The infusion was carried out in our resuscitation room with laryngoscopes and endotracheal tubes ready. We also had adrenaline 1:1000 available to give nebulised for bronchospasm.

The infusion proceeded without incident; the response was remarkable. Within an hour, our patient had settled completely; playing, and breastfeeding comfortably. We continued close monitoring for 2 hours and kept him in overnight. He was discharged the following day and has been well since.

Claire Poolman, Erik Lai
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Dengue and dengue hemorrhagic fever

Dear Editor

Doctors in Australia and elsewhere can ease fears of dengue fever in travellers to endemic regions. The dengue mosquito vector *Aedes aegypti* is active mainly during the day time, early morning or late afternoon. Nonetheless, it might bite under strong artificial light during the night. Human blood is preferred over animals, and ankles are the favourite bite area. The vector can resist desiccation for up to 1 year; eggs hatch when flooded by deoxygenated water. Larval habitats are artificial containers; larvae feed on aquatic life that develops there. Larvae die at temperatures below 10°C and mosquitoes fly only a few hundred yards from breeding sites.[1]

Traditionally, antimosquito measures are applied during the night only. Travellers, in accordance with advice from travel agents, tend to use repellents, insecticides or mosquito nets during the night. Even with otherwise meticulous nocturnal measures, they inadvertently expose themselves to bites from infected mosquitoes, especially on the lower extremities.

Australians on business travel tend to dress formally while on official engagements. During their leisure time – like those on holiday – they dress informally and expose themselves to vector bites. For protection against dengue, shorts and miniskirts need to be avoided. Australian GPs should ideally recommend dressing up in trousers, slacks or breeches for both genders. Certainly, socks should be worn while moving outdoors during day time. A pre-travel briefing by Australian GPs should lower dengue acquisition abroad and the subsequent importation of dengue by returning travellers.

Subhash C Arya, Nirmala Agarwal
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ADDRESS LETTERS TO

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Uvulitis

Dear Editor

I am all praise for Dr Gunn and his article about uvulitis (*AFP* March 2007). As a GP in my senior years, I have noticed that the uvula is hardly noticed; nay, many GPs don't seem to know what this part of the oro-pharynx is.

The picture of this young patient's throat portrays another neglected area: that of extensive oral thrush, which doubtless improved with reducing his smoking habit, and which could have been exacerbated with the antibiotic that was proffered.

My final observation is that there was no advice given to carry out throat gargling, eg. judicious use of mild antiseptic throat gargles or strong solution of table salt gargles; previously aspirin gargles were advocated but were not very helpful, carrying the risk of ulceration of the mucosa of the oropharynx, thereby compounding the problem.

Celine Aranjo
Kingsgrove, NSW

Cervical screening

Dear Editor

The March 2007 editorial states that 'inadequate' Pap test screening is an issue. The technique used in obtaining the smear must be the primary source of adequacy.

Excepting retroversion, the axis of the cervical canal is in close alignment with the anal canal. By using the lateral position and pulling dorsally on the speculum, the cervix becomes viewed at 90 degrees to the observer's visual axis. The smearing device will then be applying even pressure over the full 360 degrees with the free hand.

In the dorsal position, the cervix often needs to be substantially manipulated to obtain a similar view and an accurate smear. As most GPs for whom I have done locums did not have gynaecological examination tables, I suspect that a percentage of smears are 'inadequate' *ab initio*.

On questioning, most women expressed a preference for the lateral method. One patient with a grazing background commented that the dorsal position was 'a bit like watching my doctor through the V sight of my rifle'!

N Rogers
Ballina, NSW

Carpal tunnel syndrome

Dear Editor

We read the comments of Dr Kostos (*AFP* March 2007) concerning our recent article in *AFP*[1] and thank him for his interest. Dr Kostos correctly points out that the 'work relatedness' of carpal tunnel syndrome (CTS) has been the matter of considerable debate in the medical literature, and cites two studies quoted by Hadler[2] to support his thesis that we have sufficient evidence to suggest that in the majority of cases CTS is not work related.

The issue of the work relatedness of CTS has recently been the subject of a systematic review by Palmer et al.[3] In this review, 38 primary reports were summarised and the authors concluded that there was reasonable evidence that regular and prolonged use of hand held vibratory tools increases the risk of CTS more than twofold. Furthermore, there is substantial evidence for similar or even higher risks of CTS from prolonged and highly repetitious flexion and extension of the wrist. They point out that the balance of evidence on keyboard and computer work did not indicate an important association with CTS.

In all medical illness, attribution of cause can be difficult and most conditions are multifactorial in origin. In the case of CTS it is important to identify and manage underlying medical conditions that could be contributing to the diagnosis. However, equally it is wrong to suggest that occupational issues are not important when considering the aetiology of CTS in certain work environments. To argue in this way may deny individuals fair access to appropriate management through the workers compensation system and also miss opportunities for prevention of future cases.

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