



Fig. 2. Lateral ankle roentgenograph in a patient suffering from a rupture of the Achilles tendon. Kager's triangle is small, less transparent, and covered by a network-like shadow. Toygar's angle has decreased and is less than 150°.

patients with acute total rupture, comparing with a reference groups of ankle fractures, ankle sprains and ankles without actual trauma. Kager's triangle was positive for rupture of the Achilles tendon in all patients, 12% had diminished Toygar's angle, 48% had positive Arner's sign, and 78% of patients with ruptured Achilles tendon had a thickness of the tendon compared with the opposite Achilles tendon. To lower the frequency of overlooked Achilles tendon rupture, any doubt as to whether a ruptured Achilles tendon is present should result in a lateral soft tissue roentgenographic examination of the ankle in all age groups. However, many radiographs of the ankle are taken to enable exclusion of fracture, and this does not always lead the physician to a correct diagnosis. The roentgenographic investigation should concentrate on Kager's triangle, which is easily identified and present a good specificity and a fine sensitivity for rupture of the Achilles tendon⁸.

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Amphetamine, not MDMA, is associated with intracranial hemorrhage

A case report entitled 'Intracranial haemorrhage associated with ingestion of "Ecstasy"' is fraught with errors.¹ Chief among these errors are the misleading title and summary, as no 'Ecstasy' was involved. The authors define 'Ecstasy' as '3–4 methylene-dioxymethamphetamine (MDMA)', but go on to state that drug analysis revealed the presence of amphetamine, not MDMA. Consideration of MDMA as a possible aetiological agent was purely anecdotal, being derived from history given by a friend to the effect that the patient had 'apparently taken "Ecstasy"'. No information is presented from this friend as to the basis of her

belief — whether the patient had told her that she had ingested MDMA, whether she felt the patient's behaviour was consistent with 'Ecstasy' use, or for some other reason. While the patient's inability to speak at the time of admission explains why no history could be obtained from her at that time, her speech did return after treatment. Yet the patient's belief as to what she ingested is not reported.

Even documentation of the presence of amphetamine is inadequate: we are told that 'drug analysis detected...amphetamine at a concentration of 0.07 mg L⁻¹', but are not told whether this was the concentration of drug as sold in solution or in the patient's plasma, urine or some other bodily fluid.

Table 2, 'Management of "Ecstasy" overdose', is of potential interest but raises a number of questions. Is this protocol meant for treatment of MDMA overdose, amphetamine overdose, or both? Where did this protocol come from? Has this protocol been applied to the treatment of MDMA overdoses? If yes, what was the outcome? The recommendation of phentolamine for the treatment of hypertension in amphetamine overdose is common, but other authors have noted that phentolamine has not been proven superior to sodium nitroprusside for this indication.² Continuous infusion of sodium nitroprusside permits more precise control of blood pressure than does bolus administration of phentolamine, and deserves consideration in the treatment of acute hypertension.

The report presented is both misleading and of unclear intent. If the point is to highlight the dangers of adulteration of illicit drugs then the title should reflect this and the inclusion of an MDMA overdose management protocol is of questionable relevance. Conversely, if the intent is to address the management of MDMA overdose, the inclusion of a case involving amphetamine is inappropriate. Certainly adulteration of illicit drugs presents a variety of hazards and the MDMA-associated deaths at British rave parties were tragic and alarming. However, these points cannot justify deficient history taking or inaccurately titled reports.

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Intracranial haemorrhage associated with ingestion of 'Ecstasy'? A response¹

We apologize for the omission of a question mark at the end of the title which would have avoided any confusion. The aim of this short report was to warn practitioners of the increasing adulteration of illicit drugs in the UK, the inherent dangers for diagnostic error and the need to rely on formal drug analysis.

Patients presenting with a history of ingestion of 'ecstasy' is on the increase in the UK and therefore the management of 'ecstasy' overdose was included and based on the Welsh National Poisons Unit's Database.

The 0.07 mg L⁻¹ refers to the level of amphetamine in the patient's plasma.

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