remote places. Like diving, use of immobilising drugs should never be a solitary activity as trained support must be available immediately in case of an accident. It is also important not to rely on antidotes exclusively and not to transport a patient in the absence of ventilatory equipment, as this could be fatal. This case also demonstrated clearly that the antidote (naloxone) has a much shorter duration of action than the opiate (etorphine) and that repeated dosages of naloxone were necessary to arrest the suppressive effects of etorphine. It would therefore make sense to use naloxone parenterally, as well as an oral dose of long-acting antagonist (naltrexone) immediately after poisoning, but no studies in this regard are available.1 A dose of 25 mg seems appropriate.

The patient demonstrated the re-narcotisation of opioids caused by the mobilisation of tissue-bound opioids and the absorption of active metabolites from the gastrointestinal tract as opiate metabolites are secreted in bile. This phenomenon makes admission of all patients suffering from etorphine poisoning to hospital and a high-care facility equipped for ventilatory support mandatory. These patients should be kept under observation for at least 48 hours to ensure optimal management of re-narcotisation if need be. It would be helpful if all cases of etorphine poisoning could be reported so that treatment could be evaluated and upgraded.


---

**DIGRESSION**

“The locum cardiothoracic SHO, I presume?”

After seven years in the bush, I had found him. The legendary South African doctor, whose exploits were part of junior doctor folklore in the UK. He was sitting having lunch in a hotel in Centurion, to the south of Pretoria, having been a speaker at an infection control gathering. In fact I knew Jan ven den Ende quite well from malaria meetings (which our hospital sees a lot of — the malaria that is, not just the meetings), but never suspected how famous he was. I thought he was merely a Professor of Pathology. But on this particular occasion there was a good lunch, and out came the story.

While doing a locum SHO job in the UK for a cardiothoracic surgical firm in 1969, he attended a woman who had been stabbed in the right chest with a breadknife by her husband. He treated her with a chest drain, transfusion, tetanus prophylaxis and penicillin, and admitted her. She was seen the next day on a ward round by the consultant, who was indignant that he had not been contacted, so that he could explore the chest wound.

‘And how many chest drains have you put in then?’

‘Between ten and twenty every weekend on call for the last two years, sir.’

‘Next patient!’ said the consultant.

*C H Vaughan Williams*

*Mosvold Hospital*

*Ingwavuma, KwaZulu-Natal*