determine the erythrocyte transketolase (ETK) activity or thiamine pyrophosphate (TPP) effect on admission, or thiamine excretion. Tanphaichitr *et al*³ state that thiamine excretion alone is not a good index of the state of thiamine nutrition in an individual subject. The absence of cardiac and central nervous system manifestations may be explained partially by the fact that the patient restricted drinking and did not increase the amount of physical exercise that she took.

The potential threat of dry and wet beriberi should be kept in mind if a patient begins a strict slimming diet. Multivitamin preparations are indicated in treating the condition, but a reasonably composed diet is of primary importance.

We thank Professor Eero Hokkanen for his help in writing this report and Associate Professor Timo Kosunen for the serum B vitamin measurements.

¹ Riding, J, *British Medical Journal*, 1975, **3**, 79.

² Vinken, P J, and Bruyn, G W (ed), *Handbook of Clinical Neurology*, vol 28, p 1-41, 49-57. Amsterdam, Elsevier-North-Holland, 1976.

³ Tanphaichitr, V, *et al*, *American Journal of Clinical Nutrition*, 1970, **23**, 1017.

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Acute poisoning with Potter's Asthma Remedy

There has been recent concern in the press¹ about the increasing abuse of the popular nostrum Potter's Asthma Remedy (Potter and Clarke, Warlingham, Surrey). The active constituent of this mixture is stramonium, derived from the vegetable alkaloid contained in thorn-apple leaves (*Datura stramonium*), equivalent to 0.12% w/w of alkaloids calculated as hyoscyamine. It is sold as a brown powder, in a 90-g tin, the burning and inhalation of which is reputed to have beneficial effects on asthma. We report four cases of deliberate ingestion of this preparation because of its hallucinogenic effects.

Case reports

Case 1—A 16-year-old unemployed youth was admitted to hospital after an emergency call. He was hallucinating, with slurred speech, and was semiconscious, flushed, feverish, and responded to pain, but not to commands. Respiratory excursions were increased with a respiratory rate of 40/min. The pulse rate was 130/min with frequent atrial extrasystoles. His pupils were widely dilated and responded sluggishly to light; his limbs were flaccid with brisk tendon reflexes and extensor plantar responses. There was no neck stiffness. Urgent inquiries among his friends elicited the information that he had drunk half a tin of Potter's Asthma Remedy, mixed with tea, two hours before. As a result of the inquiries cases 2, 3, and 4 also presented.

Cases 2, 3, and 4—These were friends of the first patient. They admitted to having consumed smaller amounts of the offending substance, and they showed the autonomic side effects of alkaloid ingestion without central manifestations. They had the typical features of atropine-like toxicity—mydriasis, blurred vision, dry mouth, and tachycardia. They were observed overnight without specific treatment, and discharged the next day.

The first patient underwent gastric aspiration and lavage and was given physostigmine salicylate 2 mg intramuscularly two-hourly to a total of six doses. He did not require endotracheal intubation or assisted ventilation. Cardiac monitoring was carried out, and a sinus tachycardia, but no further ectopic beats, was recorded. He gradually regained consciousness, and could obey commands after six hours. He was fully recovered 18 hours after admission, and was discharged two days later.

Comment

Signs of alkaloid overdosage were dramatically described in 1939 as "hot as a hare, blind as a bat, dry as a bone, red as a beet, and mad as a hen."² Our first patient had blurred vision, rapid respiration, tachycardia, confusion, excitement, and coma. The suggested treatment is gastric lavage, sedation with a short-acting barbiturate if necessary, and physostigmine salicylate 1-2 mg intramuscularly or

intravenously every 1-2 hours. Oxygen and assisted respiration may be necessary. Neostigmine is of doubtful value, as it does not gain entry to the central nervous system.

Some 10 years ago there were reports from North America on misuse of substances containing stramonium,³ and recently two reports on the ingestion of asthma cigarettes in Edinburgh and King's Lynn.^{4 5} Apparently the misuse of this proprietary preparation is now sufficiently widespread in Britain for the substance to be named "goon dust" in certain circles. A disturbing feature is that one of our patients stated that a front-page article in the press had given them the idea of experimenting with the compound.¹ Review of our hospital records showed that four other cases of ingestion of "Potter's Asthma Remedy" had been admitted in the past four months. These were teenagers taking the drug for "kicks."

As there is concern about possible exploitation of this substance through "underground" channels¹ and its continuing availability, we felt that these case reports and records of treatment might be of value.

¹ *Sunday People*, 26 June 1977.

² Morton, H G, *et al*, *Journal of Pediatrics*, 1939, **14**, 755.

³ Wilcox, W P, *New England Journal of Medicine*, 1967, **277**, 1209.

⁴ Harrison, E A, *et al*, *British Medical Journal*, 1976, **2**, 1195.

⁵ Ballantyne, A, *et al*, *British Medical Journal*, 1976, **2**, 1539.

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Heart disease in life-long cyclists

The place of exercise in preventing heart disease remains uncertain.^{1 2} I thought that a survey of one of the cycling organisations catering for older cyclists would be of interest. Cycling tourists are a unique group as they tend to start young and many can and do continue into old age.

Subjects, methods, and results

The subjects were members of the Fellowship of Cycling Old Timers (FCOT), which was chosen arbitrarily, and the study was by questionnaire. The club was formed in 1965 for cyclists aged over 50 years. There was an 89.5% response to the 329 forms sent to live members, all but one in the British Isles, and most in England. Details of the cause of death of dead members (23) were obtained from death certificates. Women (12) were excluded from the study. No members had resigned at the time of the study (1973).

The pattern of activity that emerged was 5000-10 000 cycling miles a year in the early years, which fell to 2000 miles in later years. Seventy five per cent of members were still cycling regularly throughout the year, and 54 of the over-70s were cycling once a week or more throughout the year. A positive family history of heart disease was found in 45 cases. Only 23 members

Incidence and episodes of ischaemic heart disease and myocardial infarction in cyclists compared with equivalent age groups in National Morbidity Study (1971). (NMS figures in parentheses)

	45-64	65-74	≥75
No of cyclists	89 (33 182)	137 (9332)	56 (4388)
No of years at risk	252 (33 182)	426 (9332)	253 (4388)
Episodes of myocardial infarction	1 (384)	5 (179)	1 (80)
Episodes of ischaemic heart disease:			
Type I*	1 (586)	3 (294)	0 (151)
Type II†	1 (544)	8 (340)	1 (178)
Incidence of myocardial infarction:			
Per 1000 cyclist/year	3.9	11.7	4.0
Per 1000 patient/year	11.5	19.2	18.2
Incidence of all ischaemic heart disease†	3.9 (16.3)	18.7 (36.4)	4.0 (40.5)

*Episode occurring before study, as defined in NMS.

†Episode occurring during study, as defined in NMS.

admitted to being overweight at the time of the survey, and 70 had smoked cigarettes most of their adult lives. There was a 2:1 ratio of sedentary to non-sedentary workers. The incidence and episodes of all ischaemic heart disease and myocardial infarction in the cyclists is compared with equivalent age groups in the National Morbidity Survey (NMS) (1971) (see table). The drawback of comparing NMS figures, which are based on cases reported to GPs, with the questionnaire is that the latter has no details of dead FCOT members before death and the population structure is different. Only a general impression therefore is claimed from these figures. Comparison with a similar group or club of "survivors" would have been more desirable.

Comment

A decrease in the incidence of myocardial infarction and ischaemic heart disease is evident in all cyclists, but the ten-fold decrease in the incidence of all ischaemic heart disease in the over-75 group is apparent. Only three of the 23 deaths had been from heart disease, which is lower than expected. The average age of death was 79 years, high, as expected, in this club whose age of entry is 50 years minimum.

I thank the FCOT for their exceptional co-operation in this study and their secretary, Mr Derek Roberts, for great interest and support. Also I thank Dr P D Clark of the RCGP Research Unit for valuable help in compiling results and statistics.

¹ Shapira, S, *et al*, *Journal of Chronic Diseases*, 1965, **18**, 527.

² Stamler, J, *et al*, *Journal of Chronic Diseases*, 1960, **11**, 405.

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Skateboard injuries: preliminary report

From the end of June 1977 we recorded attendances for skateboard injuries at the accident and emergency department, noting details on a special form. We saw two cases at the end of July and then 52 in the next seven weeks.

Present series

Of the 54 children with skateboard injuries, nine were girls. The youngest child was 7, seven were 9, 41 were 10-13, and five were 14 and 15. Twenty-eight children were injured when skateboarding on the road, 16 on footpaths, six in the garden, two on grass slopes, one in a playground, and one in a backyard. In 32 cases the child owned the skateboard. About one board in three was home-made. One boy had had only 15 minutes' experience before he was pushed off; another fell off six hours after acquiring the

skateboard. Nine children were injured within a week of acquiring the skateboard.

Causes of the accidents were: fourteen children fell off for no apparent reason; six fell when cornering; one fell when swerving to miss a friend; one fell after a collision; and one fell when the skateboard was travelling (according to him) "at 40 miles an hour down a steep hill." Three fell when jumping off; one was pushed off; nine fell when the skateboard hit a stone or other loose obstacle; six fell when the skateboard hit a bump in the road or a manhole cover; and in two cases a stone became wedged in a wheel. One child trapped a finger when pushing the skateboard by hand, and one avulsed a fingernail when sitting on the skateboard and a wheel ran over his hand. One fell off while sitting and another when doing a handstand. Three fell when the skateboard slipped on gravel or wet leaves and one when the axle bent at speed.

Few of the injuries were serious, and only two children required admission—one with concussion and one with a displaced fracture of the lower leg. Injuries received were: bruises, abrasions, and lacerations (20 cases); sprained wrist (6); avulsed fingernail (1); injury to neck (1); concussion (1); and fractures (25). Fractures included: thumb (2 cases); radius (10; 6 greenstick); radius and ulna (1); scaphoid (6); phalanx (1); metacarpal (1); clavicle (2); tibia and fibula (1); and metatarsal (1).

Thirty-seven children underwent x-ray examination.

Comment

Skateboard injuries will probably become more common as the sport gains in popularity. If our total of 52 accidents in seven weeks reflects the incidence of accidents throughout the year in this city, we should see 386 cases in 12 months. In Hawaii¹ there were 16 admissions to one hospital in three months, including seven for concussion, one for a fractured skull, five for other fractures, one for retroperitoneal haemorrhage, and one for a ruptured spleen. Seventeen admissions to a Los Angeles hospital² over three years included one for a ruptured kidney and one for a skull fracture with cerebral contusion causing hemiplegia and aphasia.

We do not see how the accident rate in Britain can be reduced, although the provision of designated skateboarding areas would remove the hazard to pedestrians and traffic when children use skateboards on roads and footpaths. Helmets and protective pads on elbows and knees do not reduce injuries, especially to the forearms, which are the most common site of damage.

Our study is continuing.

¹ Atienza, F, and Sia, C, *Pediatrics*, 1976, **57**, 793.

² Jacobs, R A, and Keller, E L, *Pediatrics*, 1977, **59**, 939.

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