What is already known on this topic

Paediatric emergency services were under resourced in the United Kingdom, a report in 1999 found; the report made recommendations for improvement

What this study adds

Current emergency services for children in the United Kingdom still fall short of these essential recommendations

has recognised unacceptable variations nationwide in the quality of care for children and wants to eliminate these differences (the National Service Framework).^{4 5} The framework allows adult nurses to care for children only within the limits of their knowledge and should be under direct supervision of a children's trained nurse. Recruitment and retention of nursing staff is a problem in emergency departments. The Royal College of Nursing recommends rotational posts with community nursing and paediatric wards. The number of applicants for training in children's nursing exceeds the number available, so structured investment in nurse training may provide the necessary skilled nurses.

The AESC recommends that hospitals seeing more than 18 000 children should have a consultant in paediatric emergency medicine by 2004 and in all emergency departments by 2010. This, along with many of the other AESC recommendations made five years ago, has not been met and without future investment in staffing and facilities a child centred service will be hard to achieve.

Contributors: RS was the primary investigator. IKM was supervisor. IKM is guarantor.

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Competing interests: None declared.

Ethical approval: Not needed.

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DRUG POINTS

Synovitis induced by alendronic acid can present as acute carpal tunnel syndrome

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Alendronic acid (Fosamax, Merck) is a potent oral bisphosphonate licensed for prevention (5 mg daily) and treatment of postmenopausal osteoporosis (70 mg weekly or 10 mg daily).¹

A 69 year old woman had been treated for osteoporosis with disodium etidronate (Didronel, Procter & Gamble) for four years. She had a history of asthma but was not taking prednisolone. She started taking 70 mg alendronic acid a week but within 24 hours of her first dose developed synovitis in her right wrist and within 72 hours developed acute carpal tunnel syndrome. Fluid was found in the carpal tunnel when it was decompressed. No organisms or crystals were seen. Laboratory tests have included a consistently normal C reactive protein and erythrocyte sedimentation rate, calcium 2.41 mmol/l, ferritin 39 µg/l, uric acid 0.3 mmol/l, antinuclear antibodies 1/80, and negative extractable nuclear antigens, double stranded DNA, and rheumatoid factor. Nerve conduction studies showed a marked axonal lesion in the sensory median nerve. Alendronic acid was restarted at 10 mg daily five months later, but she developed pain in multiple joints after three days. The symptoms recurred on rechallenge at 10 mg on alternate days. She recovered fully when alendronic acid was discontinued.

Discussion

Synovitis is a well recognised cause of carpal tunnel syndrome. This patient had no previous history of carpal tunnel syndrome or evidence of inflammatory arthritis. Rechallenge led to symptoms in multiple joints.

Alendronic acid can cause musculoskeletal pain.² The New Zealand Pharmacovigilance Centre (<http://carm.otago.ac.nz>) holds three other reports of synovitis occurring in patients taking alendronic acid, one of whom developed a wrist effusion. Synovitis recurred when alendronic acid was re-administered after the normal dose interval of seven days in two patients and at a reduced dose after 11 days in the third. Alendronic acid should be considered a cause of synovitis or polyarthritis in the absence of any other pathology.

Contributors: DGJ identified and managed the case surgically, and JH investigated and managed the patient medically. DGJ and RS searched the literature, and RS collated and summarised other adverse reactions. DGJ is guarantor.

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Competing interests: None declared.

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