"chillout" rooms with seating and air conditioning to help cooling. For the patient who is taken acutely ill medical management is urgent and includes control of convulsions, measurement of core temperature, rapid rehydration, and possibly the use of dantrolene and active cooling measures.7

Some people taking the drug for the first time find the effects disturbing and may complain to their general practitioner of paranoia, hallucinations, insomnia, tachycardia, or muscle stiffness, including trismus or bruxism. In general, all that is needed is re assurance as these acute effects usually resolve within 48 hours. Regular users frequently chew gum to overcome the effects on their jaw muscles; they may present with weight loss, exhaustion, jaundice, "flashbacks," irritability, paranoia, depression, or psychosis.8-14

The long term effects of 3,4-methylenedioxymethamphetamine will take time to be documented in detail. At present it seems that repeated use may cause hepatic damage; it is worth mentioning ecstasy when asking about drug habits in young people presenting with unexplained jaundice.5 Perhaps the most disturbing aspect of the drug's misuse is the possibility of long term psychiatric effects. Although the drug acts as a neurotoxin at serotoninergic terminals,15,16 there is no evidence yet that it causes permanent brain damage in man. There have, however, been a few case reports of psychiatric illness,15,16 but the numbers affected are undoubtedly greater than this; it could take years until the full toll of psychiatric disorders induced by 3,4-methylenedioxymethamphetamine, including depression and suicide, is established. Claims by misusers and agencies that ecstasy is "safer than alcohol" seem premature. Although the drug does not seem addictive, relaxing the strict legal controls over a drug whose “benefits” are debatable and whose risks are evident would be unwise.17

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5 Henry JA, Jeffreys RJ, Dowling S. Toxicity and deaths due to 3,4-methylenedioxymethamphetamine ("ecstasy"). Lancet (in press).
16 McKenna DJ, Peroutka SJ. The neurochemistry and neurotoxicity of 3,4-methylenedioxymethamphetamine, "ecstasy." J Neurochem 1990;54:14-22.

Health and safety on the farm

Time to raise their status

Those who idealise rural life in Britain may be surprised to learn that many of our farmworkers face a wider range of hazards than most other workers and that preventive measures lag behind those in most other occupations. Agriculture shares with construction, mining, and fishing the dubious distinction of being a target industry for action in this the European year of safety, hygiene, and health protection at work,1 all being among the occupations at highest risk for accidental death and injury.

The agricultural sector averages one fatal injury to a worker every week and one to a member of the public every month. Farmers' health may also be affected by exposure to highly toxic chemicals, organic dusts, zoonotic infections, and a wide range of adverse environmental conditions.2 Furthermore, the hazards may extend to farmworkers' families and to visitors, whether or not they are engaged in routine farm work. Concerns also exist about the possible effects of farming practices—for example, the use of pesticides—on the environment and public health.3

Our knowledge of the extent of these problems among this scattered and diminishing working population remains sparse. As in the United States,4 there is a recognised need for improved surveillance of disease and injury; for more epidemiological investigation of morbidity, including toxicological effects, and mortality; for further study of the associated risk factors; and for devising effective interventions. If confirmation of these needs was required it has been provided by three papers published in this journal (p 25) (p 23).5 Cameron and Bishop compared the number of adults presenting with farm related injuries to a hospital in rural west Wales with official notifications of serious accidents to the Health and Safety Executive: they found that only a quarter of the major injuries were reported and that official statistics may grossly underestimate overall injury rates.6 Unless such accidents are notified intervention by the Agricultural Inspectorate to prevent further mishap is unlikely; most agricultural accidents are related to falls or falling objects, machinery, or livestock—a key factor being the failure to maintain equipment and buildings.

A wider study by the same authors shows how children under 16 account for a disproportionate number of disabling injuries and workplace deaths.7 And Croft et al, by adding further to evidence emerging from other countries suggesting that osteoarthritis should be recognised as an occupational disease in farmers, highlight the importance of lifting and other physical stresses on farms in the causation of degenerative musculoskeletal disease.8

Other occupationally related disorders, such as farmer's lung and asthma and zoonotic infections with organisms such as Leptospiros kajudo, which is common in dairy workers,8 are also unlikely to be recognised because their symptoms are often non-specific. These conditions should be notified by the farm employer or the self employed farmer under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). Even if they come to the farmer's
Trauma, back pain, malingering, and compensation

No dependable spine “lie detectors” yet

The dawn of the railway age was associated with frequent railway accidents, and many passengers suffered injuries to their spines and developed chronic back pain. “Railway spine” was often the subject of litigation. Debate raged about whether this was “concussion of the spine”, minor organic brain damage, hysteria, or deliberate malingering associated with the prospects of compensation. Similar arguments are made today in medicolegal claims for back pain.

Commonly a patient has had an accident, most often at work or in a car, and has developed back pain, perhaps referred into the lower limb. Most acute episodes of back pain resolve over a few days or weeks, but some people despite extensive treatment (which may include surgery) develop persistent and widespread symptoms and become severely disabled. The problems seem grossly disproportionate to objective evidence of damage in the spine, even that obtained with the most sophisticated investigations, including magnetic resonance imaging and computed tomography. A legal claim is made, which drags on for several years. Although agreement is reached about who was at fault in the accident, the argument continues about the severity of the injury and whether the patient is really suffering pain and is disabled.

Henry Miller introduced the term “accident neurosis” to describe a series of patients with psychoneurotic complaints after trauma. He suggested that the process of seeking compensation plays an important part in the chronicity of the symptoms. A comparison of two groups of patients with similar degrees of back injury—one group seeking compensation and the other for whom no compensation was available—supports this. It found that the severity of pain, disability, and psychological disturbance and the duration of unemployment and time off work were significantly greater in the group seeking compensation.

The compensation process itself, with its prolonged series...