

VOLUME 5

NUMBER 1

MARCH 1998

ISSN 0969-9546

European Journal of

**Emergency**

**Medicine**



Official Journal of  
The European Society for Emergency Medicine

 **Lippincott - Raven**  
P U B L I S H E R S

<http://www.emergencymed.com>

taken in combination with certain other drugs they may cause the potentially fatal serotonergic syndrome or greatly reduce the metabolism of some drugs, leading to a significant increase in toxicity. The interaction between monoamine oxidase inhibitors (MAOIs) and SSRIs is the most important drug interaction limiting SSRI use. This combination may lead to the development of a hyperserotonergic syndrome consisting of excitement, diaphoresis, rigidity, hyperthermia, tachycardia, hypertension and possibly death. The severity of this interaction necessitates a 5-week washout when switching a patient from fluoxetine to an MAOI to allow complete elimination of the fluoxetine. A 1- to 2-week washout is recommended before starting an MAOI for patients taking fluvoxamine, paroxetine or sertraline.

**BP53. Is acute carbon monoxide poisoning a difficult diagnosis in the extrahospital environment? Two case reports**

C. Genovese, R. Galbiati, E. Orlandi and M. Landriscina

*Servizio Emergenza Territoriale, Azienda Sanitaria Locale di Como, and Servizio Sanitario Urgenza Emergenza 118, Como, Italy*

The aim of this study was to demonstrate the difficulty of diagnosing acute carbon monoxide poisoning in the extrahospital environment. Carbon monoxide is odourless, does not irritate mucous membranes, is colorless and the clinical picture is nonspecific. It is common knowledge that carbon monoxide poisoning is made because of a history of exposure in an environment associated with this gas, such as an enclosed room with a natural gas-fuelled space heater. In an intrahospital phase, diagnosis is quite easy being supported by anamnestic and clinic standards and, above all, by the evidence of instrumental data. In the extrahospital setting, a diagnosis of carbon monoxide poisoning is very difficult when there is no suspicion of such an event occurring, when the usual risk situations are not in evidence and when there is no sign of collective intoxication. Case 1 was a 25-year-old female suffering from recurrent headaches. She was evaluated in October 1997 for epileptic stroke. A computed tomography scan and an electroencephalogram were both negative. She had been found unconscious on the floor of her bathroom. She was treated according to ABC rules. Ventilation was supported artificially by oro-tracheal intubation. The presumed diagnosis was an acute neurologic disease instead of carbon monoxide poisoning. Case 2 was a 55-year-old male. No anamnesis was known. He was found

inside a truck in a parking area. Even in this case, the patient was treated according to ABC rules and pure O<sub>2</sub> was administered. But carbon monoxide poisoning was not directly suspected because the truck engine was off and the environment was not the usual one for carbon monoxide poisoning. Anamnesis in the first case, and the unusual setting in the second one, led to a misunderstanding of the diagnosis of carbon monoxide poisoning. Carbon monoxide intoxication is rarely suspected because the clinical signs are often inconspicuous. A cherry colour in the skin and mucous membranes indicates severe poisoning but this was not present. Both patients were unconscious, so that it was not possible to recognize objective symptoms such as nausea and headache. Because of the particular setting in which the man was found, the identification of a risk factor was difficult because the problem was a gas-fueled heater which was handmade and had been placed outside the truck. In conclusion, the emotional state of whoever calls the emergency service and omits essential data, the lack of careful investigation, the failure to recognize obvious clues, anamnestic data collection, unusual environments, the presence of a single victim, and the absence of the seasonal factor can all lead to a failure to diagnose carbon monoxide intoxication.

**STROKE**

**BP54. Early changes of motor cortex excitability in ischaemic stroke: preliminary findings**

V. Di Lazzaro, D. Restuccia, P. Profice, A. Oliviero, D. Iacono, E. Saturno, F. Pilato and P. Tonali

*Institute of Neurology, Catholic University of the Sacred Heart, Rome, Italy*

Motor-evoked potentials after magnetic transcranial stimulation and the excitability of the motor cortex to increasing magnetic stimulus intensities were evaluated in six patients with hemiparesis after ischaemic stroke within 8 h from the beginning of symptomatology. The diagnosis of stroke was made clinically and location of the infarction was confirmed by computed tomography scanning. The disability was evaluated using the sub-scale 5 of the NIH stroke scale. We investigated central motor circuits in six unselected consecutive patients with stroke (mean age 70 years (SD 3