Steroid use and chemotherapy were also significant risk factors for 12 month mortality [odds ratio (OR) 1.4, 1.2 – 1.6, \( P < 0.001 \) and OR 1.5, 1.2 – 1.9, \( P < 0.001 \), respectively] (Table 1).

Our ICU, in-hospital, and 12 month mortality are comparable with published studies in non-cancer populations of ICU long stayers, allowing for differences in case mix and definition of long stay.1–6

We report that more than half of long-stay critically ill cancer patients survive 1 yr or more. Our data demonstrate that even within the group of long-staying cancer patients on ICU, there are patients who have good long-term prognosis. Here, we were also able to identify several risk factors for increased mortality (respiratory failure, chemotherapy before ICU admission, and use of steroids) that if validated could aid in individual patient risk stratification for long-stay oncology patients in the ICU and serve as starting points for future investigations to improve the outcomes of this patient subgroup.

**Declaration of interest**

None declared.

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**Key-ring data sheet to provide critical information required in managing paediatric emergencies**

Editor—Emergency situations in paediatric anaesthetic practice are extremely stressful for all involved. In these scenarios, even small errors in calculations can prove to be catastrophic for the patient. Anaesthetic trainees are frequently required to anaesthetize paediatric patients in an emergency setting and need a robust system for obtaining clinical information to ensure patient safety.

A recent survey at Nottingham University Hospitals revealed that anaesthetists of all grades felt under confident when managing children <5 yr of age, especially as the ASA grade increased. In an effort to address this, we developed a Paediatric Anaesthetic Emergency handbook from local and national guidelines. To accompany this, we also produced a key-ring with a ‘pull-out’, double-sided information sheet (Fig. 1 on next page). This key-ring data sheet contains useful formulae and normal physiological data, as well as drug dosing and infusion preparation information, all colour-coded using the standard anaesthetic drug labelling format. The aim of this device was to provide the anaesthetist with critical information quickly and easily, without the need to access electronic information sources, which can be difficult or impossible to do during an emergency.

These key-ring devices have proved to be an extremely popular and highly convenient information source with anaesthetic trainees and consultants (both paediatric and non-paediatric) alike. Indeed, they now seem to be the ubiquitous attachment to all anaesthetic department ID badges! We have also received a lot of interest from other departments around the hospital, including the paediatric intensive care unit, paediatric emergency department, general paediatrics, and the neonatal unit. We have now begun, in discussion with these departments, to develop speciality-specific versions of the key-ring data sheet for each of these areas.

**Declaration of interest**

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**Knowledge related to anaesthesia among laypeople**

Editor—An audit to assess the knowledge related to anaesthesia in laypeople was recently carried out. A questionnaire, based on an AAGBI patient information leaflet ‘Anaesthesia Explained’,1 was completed by 73 patients randomly selected from those attending a rural GP practice. Questions were asked on the qualifications and roles of the anaesthetist, and some of the common side-effects of anaesthesia.

Of the 73 participants, 93.2% (n = 68) knew that anaesthetists were medically qualified; however, only 43.8% (n = 32) identified the anaesthetist as a doctor, with 41% (n = 30) mistaking the anaesthetist for an Operating Department Practitioner. The minimum training period of an anaesthetist from...
leaving university to attaining a Certificate of Completion of Training (CCT) was identified most popularly as 3 yr (20.5%, \( n = 15 \)), 4 yr (20.5%, \( n = 15 \)), and 5 yr (34.2%, \( n = 25 \)); 8.2% of patients thought it took < 2 yr to attain a CCT.

With regard to the role of the anaesthetist, 87.7% (\( n = 64 \)) of participants identified that the anaesthetist is responsible for administering the anaesthetic. Other roles were less well understood. Significantly, just 13.7% (\( n = 10 \)) knew that anaesthetists are responsible for administrating blood transfusions intraoperatively and 20.5% (\( n = 15 \)) identified that providing analgesia is a key role of the anaesthetist.

Figure 1 opposite illustrates the knowledge of potential side-effects after anaesthesia.

If patients are aware that the anaesthetist has a wider role than just administering an anaesthetic, they will be empowered to discuss the different options available and make a fully informed choice. This will help shift the dynamic of the doctor–patient relationship away from paternalistic care, and decrease patient anxiety before operation.

It is likely that the gaps in patient knowledge will be filled by the anaesthetist before operation, either at preoperative assessment clinics or during the consent process. However, it can often be difficult to cover all necessary aspects verbally due to time constraints, and the level of understanding patients have can easily be overestimated. Literature such as the Anaesthesia Explained booklet should be utilized in patient areas to help aid this process, although it has previously been shown that verbal communication is the most effective way of decreasing preoperative anxiety. Thus, practitioners must remember the onus remains on them to ensure patients are fully informed of their role before anaesthesia.

Fig 1 Front and back images of paediatric anaesthetic data key-ring.
Growing menace of ibogaine toxicity

Editor—Ibogaine is an hallucinogenic alkaloid derived from a western African shrub. Although in recent years some degree of experimental evidence has emerged favouring the use of ibogaine in the management of substance abuse disorders, these developments have been overshadowed by concerns about its safety and several cases of unexplained sudden cardiac death have been associated with its use.1,2 Among its pleiotropic receptor effects, ibogaine has central 5HT-2A agonist activity, and through this mechanism it prolongs the QT interval.3

Although ibogaine is not approved by any drug administration agency in the world, its unauthorized use in clandestine detoxification clinics is steadily growing worldwide. We describe the first case of severe ibogaine toxicity in the UK and highlight the complexities posed by its management.

A young Afro-Caribbean man was admitted to hospital with vomiting and agitation, after being found by his relatives in a state of confusion. He had ingested a total of 7 g of ibogaine to soothe the symptoms of heroin withdrawal. He denied ingestion of alcohol or any other drugs and he had not used heroin or methadone for >72 h. There was no family history of heart disease. Initial laboratory blood tests, arterial blood gas analysis, cardiac enzymes, and urine toxicology were unremarkable.

The patient was in sinus bradycardia, with marked prolongation of the QTc interval (600 ms). Several brief, self-terminating bursts of polymorphic tachycardia (VT) occurred. The VT was initially associated with tonic-clonic seizures and the patient rapidly deteriorated, losing cardiac output, and developing torsades de pointes cardiac arrest. Spontaneous cardiac output was initially restored by defibrillation (200 J), but pulseless torsades de pointes recurred despite treatment with i.v. magnesium (8 mmol), atropine (2 mg), epinephrine (4 mg), and isoprenaline (5 µg min⁻¹). The patient was defibrillated several more times and required tracheal intubation to secure his airway. Transcutaneous overdrive pacing immediately shortened the QT interval and controlled the ectopic ventricular activity. The transcutaneous pacemaker was promptly replaced with a temporary transvenous pacing wire. The patient was paced at a rate of 80 beats min⁻¹ for 48 h, without further episodes of VT. The patient’s bradycardia resolved and the QT interval spontaneously returned to 420 ms. The pacing wire was removed and the patient was weaned from mechanical ventilation. No further abnormalities were detected on subsequent ECGs and a transthoracic echocardiogram was normal. A review by a consultant cardiologist determined that no further electrophysiological testing was required. The patient had an uneventful recovery and was rapidly discharged.

This case summary represents the first report of ibogaine intoxication in the UK. In view of the growing use of this drug...