Morbidity resulting from snakebite represents a significant global healthcare burden, especially in developing tropical countries. It is impossible to gain precise data on this subject however, it has been estimated that over 5 million instances of snakebite occur each year worldwide resulting in 125,000 deaths. The death rate from snakebite is higher in densely populated countries particularly in sub-Saharan Africa and South East Asia. The United Kingdom has just one native venomous species, the Common Adder or *Vipera Berus*. About 100–200 Adder bites are recorded in the UK each year; the last reported death occurred in a child over 30 years ago. Staff in emergency departments in Britain should be able to deal with native Adder bites, however, how would they cope with bites from exotic species that are significantly more dangerous to humans? The review by Worrall considers envenoming caused by such species in the UK. Incredibly, dangerous snakes are sometimes kept as pets and the victim is usually the owner. Snake venom represents a complex set of proteins with widely varying toxicities (cyto, neuro, cardio and haemotoxic). Prompt diagnosis is needed and correct management will require specialist knowledge of the species concerned. Professor Worrall’s review is extremely useful in this respect and uses a number of case histories to illustrate the main principles of snakebite management.

One of the significant and unwanted complications of glycaemic control in insulin dependent diabetes is hypoglycaemia. Most patients will learn to recognise the symptoms of incipient hypoglycaemia during the daytime and take appropriate corrective action. Nocturnal hypoglycaemia (NH) however may be both severe and unnoticed. In some cases it may cause cardiac arrhythmia and result in the so called “dead in bed syndrome”. Chronic recurrences of unrecognised nocturnal hypoglycaemia may result in cognitive impairment. There is also the Somogyi effect which describes a high morning blood sugar that is a response to low blood sugar during the night. Hence nocturnal hypoglycaemia is a complication to be avoided. In their small study, Woodhall et al, explore the frequency and predictive factors for nocturnal hypoglycaemia in 25 patients with type 1 diabetes. It was found that nocturnal hypoglycaemia was relatively common with 14 episodes of NH occurring in 12 subjects. NH was more likely to occur if both bedtime and morning blood glucose levels were low. Perhaps the main take home message from this pilot study is the need for more use of continuous blood glucose monitoring in insulin dependent diabetics.

The benefits of exercise with respect to reduction in cardiac risk factors and subsequent adverse incidents are universally acknowledged. Most governments urge their citizens to be more active and to engage in exercise. However, which type of exercise is best and how much is needed for healthy living? We are constantly reassured that gym membership is not essential and periods of brisk walking may be sufficient for many. This month’s edition of *QJM* includes a population study from Greece that evaluated the impact of adding resistance exercise to aerobic activities in a representative sample of men and women from the province of Attica. The main outcome measure was lipid-lipoprotein profile. In short, it was found that those individuals who combined resistance activities with aerobic exercise had a better lipid-lipoprotein profile than those who engaged in aerobic activities solely. The conclusions from this study have implications for the advice we give our patients. I acknowledge that this is a complex (and controversial) subject area. There is a need for more clarity and the Editor would welcome an authoritative review on this subject.

“Statins are good for you” proclaimed the headline from a UK evening newspaper.

The article described the support given by several authorities to the notion of giving statins to a wider population of subjects that did not have existing
cardiac disease or diabetes. In the opinion of many, statins are wonder drugs. If we were to prescribe them to large numbers of the population, would there be any safety issues that should be considered? One of the known side effects of statins is myopathy with subsequent reduction in muscle function. The question is whether this effect has any clinical significance. We publish a paper from Australia that is likely to provoke debate and some degree of controversy. The authors sought to determine whether statin use could be associated with reduced muscle function and hence increased risk of falls in older adults. Muscle mass and function were evaluated in older individuals who were taking statins and compared to those who were not prescribed this medication. It was found that statin use may cause decline in muscle function with a subsequent increased risk of falls in older adults. The effect appears reversible with cessation of statin therapy. The results of this study would need to be interpreted with some caution and further evaluation of this apparent association is required.

Finally, we are proud to publish the abstracts of this year’s Annual General Meeting of the Association of Physicians. The standard was again exceptionally high. I was particularly impressed with the number of quality presentations from young researchers – this bodes well for the future.

Michael Bannon

Editor, QJM