

Letters to the Editor

30 years of SPUMS index encoded as an Endnote™ library

Dear Editor,

One of the problems the diving and hyperbaric medicine community faces on a daily basis is that many extremely valuable publications are not easily accessible. Much exciting data are published but not indexed on electronic search engines such as Embase or Medline. Finding published information on a particular topic is often dependent upon the number of people you talk to and what they remember. E-mail discussion lists such as the ANZHMG list therefore come into their own by offering exposure to a large group of interested colleagues.

The SPUMS Journal itself has been indexed on Embase since 2000. A CD-ROM* is available from SPUMS that includes an index of all material published from 1970 to 2000 (a total of 2,744 citations). The available index is however written as a tabbed data file for conversion into a Microsoft Access Database or Microsoft Word and is as such not particularly user friendly.

I have re-arranged the available index and have written a filter to convert the index into an Endnote™ library. Endnote™ is one example of a number of computer programs that facilitate research and publishing in a tremendous way. Produced by ISI Researchsoft (<http://www.endnote.com/enhome.htm>), the latest version of Endnote™ (Version 6) allows the user to search bibliographic databases on the Internet, organise references and images in a database, and automatically create a reference list formatted for any specified journal via its "Cite While You Write" (CWYW) function. It has advanced import and export functions, 28 customisable reference types with 40 fields for entering reference and image data, and stores up to 32,000 records per database.

The program comes with an extensive manual (either in book format or on CD). It took me less than two hours to get up and going. Much learning is done by actually writing your next publication and trouble-shooting as you go (an easy task with the existing help function and the manual). The SPUMS Endnote™ library has eased my own research tremendously and it may be of help to anyone trying to find a particular topic in previous SPUMS publications. I have not, however, cross-checked all references with the real publications and will take no responsibility for the correctness of the information included in the library.

I am very happy to make the library publicly available and hope that this represents a step closer to a combined infrastructure for research and knowledge in our field. I do hope that in the near future we will be able to up- and

download similar databases in one place (maybe the SPUMS web site?) to make life easier for us all, and our patients.

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*CD-ROMs containing back copies and the index of the SPUMS Journal from the first issue in May 1971 to December 2000, can be purchased from the SPUMS Administrator, C/o ANZ College of Anaesthetists, 630 St.Kilda Road, Melbourne, Victoria 3004, Australia. Price \$Aust25.

Editor's note:

This matter was discussed at the recent ANZHMG Annual Meeting in Christchurch. It is proposed to build on Dr Neff's efforts in a collaborative manner between the Australasian hyperbaric units, since much valuable research in the diving medicine field has been published in non-indexed form. Meanwhile, his commendation of this software is endorsed by others.

Reverse dive profiles

Dear Editor,

I refer to Guy Williams' presentation at Madang 2001, on reverse profile diving.¹ The following week, I was diving at Tufi and I had occasion to test this thesis. I had done two reef wall dives in the morning, maximum depth 30 metres, duration 60 minutes on each dive. In the afternoon, I wanted to dive the wreck of a patrol boat located in the fiord just off the jetty at a depth of 50 metres. None of the others in the group were interested in this dive, so I went down with a divemaster/guide who had not dived that day.

It took 3 minutes to reach the wreck at 50+ metres and I spent 10 minutes taking photographs. By this time, my computer was well into the red zone, signalling 20 minutes decompression time. The divemaster told me later his computer indicated one minute to decompression time when I signalled to ascend.

I took 4 minutes to reach 20 metres, where I spent 2 minutes, 2 minutes to 10 metres resting 4 minutes, then it took 21 minutes at 5 metres before my computer came back into the green and I considered it was safe to surface. I felt no after effects from the dive, but recorded a high residual nitrogen level starting my first dive next morning.

Air consumption was interesting. I had a 90 cubic foot tank filled to 3600 psi and a redundant 20 cubic foot tank filled

to 3000 psi. A 'hang' tank was located at 5 metres. I was down to 1500 psi at the start of the ascent, 730 psi at 5 metres and I surfaced with 180 psi left. I could have switched to my reserve tank, but was curious to see if I could complete the dive on one tank.

I suppose the moral of this story is that you can do reverse profile dives safely, but you pay for it with long decompression times and a high residual nitrogen level.

W F Brogan
City Beach, W A

Reference

- 1 Williams G. Reverse dive profiles. *SPUMS J* 2002; 32: 109-110

Reply

The presentation re reverse dive profiles related to the blanket prohibition of reverse dive profiles – reverse dive profiles may not be always the most efficient use of dive time. The recommendations relate to dives less than 40 metres and differentials less than 12 metres – divers need to plan repetitive dive profiles to make the most efficient use of dive time.

Guy Williams
Rosebud Medical Centre, Victoria

Editor's note:

The sequence of dives described by Dr Brogan is outside that usually associated with recreational scuba diving.

Neurological symptoms developing while diving

Dear Editor,

We were interested to read the article by Bateman and Sawyer¹ reprinted in this journal (*SPUMS J* 2002; 32: 60). In this brief case report, a single MRI film of the cervical spine of a young woman who suffered presumed decompression illness whilst diving in Egypt, is presented. The report notes that she had an unsustained improvement in her neurological symptoms and signs with recompression therapy. The report goes on to say that on the basis of this MRI, a diagnosis of transverse myelitis was made and the patient then treated with steroids.

There are a number of issues that this case raises.

First, the MRI appearances of cervical spine lesions in decompression illness are characteristically lenticular in appearance, as is the one demonstrated, and often occupy several dermatomes, as is also the case here. It has been

our experience that where significant lesions like this are present, there are almost certainly other lesions within the central nervous system, either in the lower spinal column or within the cranium. It would be interesting to know whether such multiple lesions were present, since this would exclude a transverse myelitis of a non-diving aetiology. Without that additional information the diagnosis of a non-diving transverse myelitis cannot be made.

The second issue is the one of recompression therapy. We do not know whether this was a single treatment, what type of treatment was administered and whether there was any follow-up hyperbaric therapy. In our experience, it is not uncommon for signs and symptoms to relapse to some degree in severe cases, even following an extended Royal Navy Table 62 or other major initial hyperbaric treatment. A varying pattern of gradually diminishing neurology is one that would be familiar to all those who have treated this condition. Therefore, neither the relapse nor indeed the supposed response to steroids precludes the diagnosis remaining that of decompression illness.

We remain unconvinced by the data presented that this woman suffered from anything other than neurological decompression illness.

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Reference

- 1 Bateman RM, Sawyer RN. Neurological symptoms developing while diving. *Brit Med J* 2001; 323: 242

Medical conditions and diving deaths

Dear Editor,

The strongly-worded statement regarding medical conditions, specifically asthma, and their contribution to scuba diving fatalities made by Davis et al¹ cannot be allowed to go unchallenged. The authors base their statement on the presence of medical conditions established by history or at autopsy that were "believed to have contributed to the death". No data are given in the paper, however, as to the basis of this belief and the authors could not supply me with any further details when I contacted them. These details are apparently simply not available.

The problem here is that the argument is a circular one. Suppose one believes that the human foreskin is an important route of nitrogen excretion. One then would