temporarily raise blood Hg levels through inhaling more vapour”. We would like to add that since 2003 we have developed a new technique for the removal of amalgam. This procedure makes it possible to control the release of mercury vapour during amalgam-replacement therapy because the entire mercury filling is removed en bloc, and mercury levels in saliva, blood, and urine did not oscillate from baseline levels.

References


Authors’ reply

To the Editor—We agree to Guzzi and Pigatto’s comment that the blood and urine level of mercury may not reflect the body tissue burden of mercury. For mercury-poisoned patients, the best marker for body tissue burden should be the concentration in the effector organs, ie the brain and kidneys. However, in most scenarios, these concentrations are not measurable unless at autopsy. It is not practical to rely on these measurements to diagnose mercury poisoning. Therefore, in the report, we have stressed the importance of obtaining a detailed exposure history, evaluating the clinical signs and symptoms and measuring the blood and urine mercury levels. As for Guzzi’s technique of amalgam removal, we have no further comments.

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Malpractice claims: corrections

To the Editor—The authors in the Commentary “Medical malpractice: prevention is often a better strategy” in the October 2011 issue would like to make two corrections.

First, the Bolam case was quoted under the wrong name of Bolam v Chelsea and Kensington Hospital Management Committee [1968] 1 QB 428. It should have been Bolam v Frien Barnet Hospital Management Committee [1957] 2 All ER 118. In Bolam, McNair J enunciated the legal requirement for the standard of care in medical negligence, which is that in accordance with a practice accepted as proper by a responsible body of medical men skilled in the particular art. In another case, Barnett v Chelsea and Kensington Hospital Management Committee [1968] 1 QB 428, a watchman arrived in the Accident and Emergency nauseated after a cup of tea. The casualty doctor simply advised that he should see his general practitioner. The man died 5 hours later from arsenic poisoning. The court found that the man would have died anyway because it was too late to save him and it was not the casualty doctor’s negligence that had caused his death. The claimant thus failed to establish causation. This
case incidentally illustrates well the point raised in the second paragraph of the article that a mere adverse outcome is not a sufficient condition for a successful negligence claim. This second case was originally in the authors’ initial drafts but deletion of words due to length restrictions resulted in the erroneous hybrid name printed in the final script and the authors apologise for that.

Second, the word “tortuous” on the first line of the third paragraph on the right hand column of page 425 should have been “tortious” (pertaining to “torts”, ie wrong doing).

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Note from Editorial Department: This article which appears on www.hkmj.org has been corrected.