(Fenoterol hydrobromide and ipratropium bromide) a β agonist/anticholinergic were administered. This prevented the wheezy cough and overswing into retching. With this simple expedient the athlete was mobile within 15-20 mins, a normal 400 m recovery time. Fluids, in the form of ionic/glucose replacement, were administered as Isostar and Perform(Wander) plus Gaterade all of which were made up more dilute than instructed by the manufacturers and between the heats and semi-finals no solid food was taken. Duovent had to be repeated several times over the two days of competition and the following day. The athlete recovered on every occasion without any vomiting or abdominal pains and reached the finals in his fastest time ever. The athlete was able to walk and complete his own warm down (an essential ingredient of this management) within 20 mins.

This athlete had been in severe distress on many race occasions and this management was the first that had enabled rapid recovery without distress which of course must improve the psychological approach to the race. I have my doubts as to the contribution of the sodium bicarbonate which was used in considerably smaller doses than that recommended (300 mg.kg^{-1}) and because of the side effects even at this small dose it presents problems in usage. I feel that all we did was to enhance the warm down, removing lactic acid whilst restoring venous return, maintaining cerebral circulation and reducing coughing.

Yours sincerely,

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Dear Editors,

I would like to report a case of bilateral shoulder dislocation.

A healthy 24-year-old male library assistant had been weight training regularly for 2 years. After warming-up exercises, he usually performed 3 sets of 15 bench presses with a 40 Kg barbell. In this lift, the lifter grasps the bar with the hands about a shoulder width apart whilst lying horizontally on a bench (see cover photograph). The bar is then lowered to the chest and pushed back up to the starting position. On the fifteenth lift of the first set both arms suddenly became stiff and painful. He lost control of the weight which fell backwards but was caught by his training partner. Shoulder movements were very painful and tingling was noted over the outer aspect of both shoulders. He then attended the Accident and Emergency Department.

On examination, he was a well-built man and both shoulders appeared to be clinically dislocated. Movement at the gleno-humeral joints was virtually nil. Hypoaesthesia was noted in the distribution of the upper lateral cutaneous nerve of the arms bilaterally. There was no vascular abnormality.

X-rays showed bilateral anterior dislocations. No fractures were seen.

Reduction was achieved using Kocher's manoeuvre after 50 mg of pethidine and 10 mg of Medazolam intravenously. Post-reduction films were satisfactory and reduction maintained using bilateral collars and cuffs and a body bandage. He was allowed home the following day. He was reviewed one week later in outpatients, axillary views were taken and were normal.

Review at 3 weeks after the injury showed no neurological deficit in the right arm, but on the left there was wasting of the posterior half of deltoid with overlying hypoaesthesia. The collars and cuffs were maintained for a further 3 weeks. Examination at that time showed the hypoaesthesia to be present, but much improved. Abduction was 90 degrees bilaterally. The bandaging and collars and cuffs were discarded and the patient advised against external rotation. Review at 9 weeks showed a full range of movement with slight blunting of sensation over the left deltoid. The patient failed to attend any further follow up.

Bilateral anterior dislocations of the shoulders (with or without fracture) is rare with only 38 cases reported in papers by Brown (1984), Carew-McColl (1980), Hartney-Velazco et al. (1984), Onabowale et al (1979), Salem (1983) and Yadav (1977) in a literature search. Of these cases, 17 were due to electrocution or seizure and 18 were due to considerable direct violence such as falls, overturning tractors and falling embankments. The remaining 3 were seen in cases with neuromuscular disease, namely myasthenia gravis, cerebral palsy and scapular myopathy. This case seems to be unique in that it involves a healthy male performing an exercise previously within his capability. No report of the bench press being the aetiological factor was found. The position used to perform the bench press is ideal for dislocation, as there is forced extension, abduction and external rotation of the arm which levers the humeral head out of the glenoid. With the current vogue for fitness, it is a surprisingly rare injury.

Yours sincerely,

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The author thanks Mr. John Campbell for allowing this report on his patient and Dr. Tim Dawson for his help.

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