

of collapse.²⁻⁴ Minimising the time above the critical threshold for cell damage decreases the extent of tissue and organ damage within the body. Demartini and colleagues showed that, when body temperature was reduced below the critical threshold in 274 individuals who had succumbed to EHS, there was 100% survival without any known sequelae.⁵ Second, the mode of body cooling should be such that the cooling rate is optimal (>0.15°C/min) for EHS treatment.⁶ Alternative options such as tarp-assisted cooling have been shown to be just as effective as cold-water immersion and can be implemented with ease.^{7,8}

To optimise the treatment and care of individuals suffering EHS, it is essential that patient care take an interdisciplinary approach. Coordinating care between onsite medical providers (for example, athletic trainers, other sports medicine professionals), emergency medical services, and primary care physicians allows for a seamless transition of care between medical providers to optimise patient outcomes.

William M Adams,

Assistant Professor, University of North Carolina at Greensboro, US.

Email: wmadams@uncg.edu

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Minimising iatrogenic nerve injury in primary care

Wallis and colleagues did not find any cases of nerve injury relating to contraceptive implant insertion/removal in the New Zealand claims dataset. However, such injuries were first reported more than 20 years ago with the 6-rod Norplant and frequently lead to litigation. I have seen 11 such cases in my medicolegal practice. The site for such injuries is the sulcus between biceps and triceps in the upper arm, 8–10 cm above the medial epicondyle. Three nerves run in a neurovascular bundle just below the fascia: the median, ulnar, and medial cutaneous nerve of the forearm. All three have been injured at the time subdermal implant procedures are performed.²⁻⁶ These injuries continue to happen, despite the recommended site for insertion having been moved away from the sulcus in 2008. The injuries generally occur when blind instrumentation is performed during attempts to remove implants that are situated deeply or are tethered. Some women have suffered permanent neurological deficit, despite undergoing neurolysis procedures. In my view, routine removals should only be carried out by the 'pop-out' technique (for a nice demonstration of this, see this videoclip: bjgplife.com/popout). Attempts at removal should be abandoned if not straightforward or if the woman complains of sensory symptoms.

Sam Rowlands,

Visiting Professor, Bournemouth University.

Email: srowlands@bournemouth.ac.uk

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Corrections

Research by Shephard EA and Hamilton WT, Selection of men for investigation of possible testicular cancer in primary care: a large case-control study using electronic patient records. *Br J Gen Pract* 2018; DOI: <https://doi.org/10.3399/bjgp18X697949> showed an inaccuracy in the print version. The printed version states 'Testicular swelling alone has a PPV for cancer just below the 3% threshold, but when combined with testicular, groin or abdominal pain, particularly in men aged >50 years, the likelihood of cancer is considerably greater.' The corrected version should read 'A testicular lump alone has a PPV for cancer just below the 3% threshold, but when combined with testicular swelling, pain or abdominal pain in men <50 years, the likelihood of cancer is considerably greater.' This appears in the grey box at top of print abridged version only. The online version is correct.

DOI: <https://doi.org/10.3399/bjgp18X698513>

Research by the DAMASK Trial Team, Cost-effectiveness of magnetic resonance imaging of the knee for patients presenting in primary care. *Br J Gen Pract* 2008; DOI: <https://doi.org/10.3399/bjgp08X342660> showed mean QALYs over 24 months as difference = 0.050 and 95% CI = 0.025 to 0.118 in the Abstract and Table 4. The lower CI is missing a minus, and it should read -0.025 to 0.118, around a difference of 0.050. The online version has been corrected.

DOI: <https://doi.org/10.3399/bjgp18X698525>

In the study by Davies J *et al*, Long-term benzodiazepine and Z-drugs use in the UK: a survey of general practice. *Br J Gen Pract* 2018; DOI: <https://doi.org/10.3399/bjgp17X691865>, the data for the general population of NHS patients in 2014 were for England only, rather than the UK as a whole. The correct article title is 'Long-term benzodiazepine and Z-drugs use in England: a survey of general practice', and there are changes throughout the article to reflect this. The online version has been corrected.

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