tially at risk mothers will be influenced to have their babies at home. The number of women previously selected for consultant deliveries who have their babies at home will increase, and the perinatal mortality will rise. Sadly we are now witnessing some of the consequences of the pressure for home deliveries which has put babies' lives at risk and resulted in brain damage. It will take some time before these individual tragedies are reflected in large studies such as this one, which is published five years in arrears.

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Do minor affective disorders need medication?

SIR,—Professor H G Morgan makes many glib assertions about minor affective disorders (29 September, p 783). He does not define the difference between these disorders and others which call for psychotropic drug treatment except to suggest that the former "may not be associated with severe disturbance of behaviour or disruption of normal life." Does he think the intensity of distressing symptoms does not count though distress can be so quickly reduced with medication?

Professor Morgan draws no distinction between the properties and effects of antidepressants and tranquillisers. He ignores recent advances in safety with newer antidepressants. Effective antidepressants can be prescribed which do not create "proneness to road traffic accidents, excessive dependence with adverse reactions on withdrawal, deliberate self poisoning, aggressive outbursts. . ."

Does he think that "endogenous disease" is the indication for prescribing and "reaction to upsetting events" is not? This view would utterly ignore the multitude of mixed neurotic/endogenous depressions, the frequency of endogenous depression in reaction to upsetting events—for example, bereavement—and the efficacy of monoamine oxidase inhibitors in so many "reactive" depressions, etc.

Professor Morgan conveys an appeal for more psychotherapy to be practised by general practitioners *instead of* prescription of psychotropic drugs. A better emphasis would be more psychotherapy *in addition to* meticulous psychotropic drug treatment. Good psychotherapy has been practised for millennia. Pharmacological innovation in the past 35 years has probably been the biggest advance in the history of treatment of affective disorder.

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Unrecognised psychiatric illness in medical patients

SIR,—Sir John Nabarro has highlighted the problem of recognising psychiatric disorders in medical patients (15 September, p 635). We have attempted to determine the incidence of depression in our gastrointestinal/general medical outpatients and whether a simple screening test would improve our diagnosis of this disorder. Self assessment questionnaires, such as the Beck depression inventory, can be used for rapid screening.¹

Fifty of 100 consecutive referrals had an inventory score consistent with a diagnosis of depression, nine of them severe. Knowledge of the inventory score increased the propor-

tion of depressed patients who were prescribed antidepressants from 36% to 57%. Two thirds of the depressives had no demonstrable organic disease and most complained of irritable bowel symptoms or abdominal pain.² One moderately depressed patient referred with altered bowel habit and abdominal bloating who received antidepressants committed suicide a few days later.

In answer to some of the questions raised by Sir John, depression is common in gastrointestinal/general medical outpatients and self assessment questionnaires can be used to increase its recognition. Many patients seen by us have had several volumes of case notes recording multiple admissions, outpatient attendances, and surgical and gynaecological intervention without an appreciation of the underlying diagnosis. Early recognition of depression in medical patients is not only good medicine but reduces excessive expensive investigation and treatment.

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1 Beck AT, Beck RW. Screening depressed patients in family practice: a rapid technic. *Postgrad Med J* 1972;52:81-5.

2 Rose JDR, Troughton AH, Smith PM. Beck depression inventory screening of gastrointestinal outpatients. *Gut* 1984;25:1147.

SIR,—Sir John Nabarro declares that it is impossible to decide whether the psychiatric illnesses we described in our paper (15 September, p 635) were missed by the consultants or by the registrars. The answer to this is that they were not recognised by anyone on the medical staff. Dr R A Metcalf (20 October, p 1075) considers that the disorders may have been recognised, but not recorded in the notes. We deemed an illness to be recognised if any reference at all was made to the patient's emotional state, either in the medical notes, in the letter to the general practitioner, or by the prescription of a psychotropic drug. We think that we leant over backwards to give the neurologists the benefit of the doubt. We cannot think that it would be reasonable to have elicited such a disorder but not to think it worth mentioning either in the notes or to the patient's family doctor.

Dr Metcalf also asks how many of these illnesses were serious. We think that some intervention would have been appropriate in all of them in the form of discussion and that psychotropic drugs would also have been useful in about 60%.

We share Dr A P Boardman's view (6 October, p 919) that Sir John's suggested solution—more consultants—would be nugatory unless the consultants knew how to interview their patients in such a way as to allow details of such disorders to emerge and were provided with proper rooms in which to carry out such interviews. Extra time on its own does not do the trick. We agree with the suggestion made by Professor Neil Kessel (20 October, p 1076) that more thought needs to be given to the objectives of the preregistration year so that housemen can receive more guidance in detecting and managing common psychiatric disorders.

We were interested in the point of Dr Michael Saunders and Dr Christine Kirk (6 October, p 919) about the coexistence of psychiatric ill health and organic neurological

disease but cannot agree that their own work leads to the conclusion that the general health questionnaire is an unreliable guide to such illnesses. They used an unstandardised interview of their own devising to interview their patients and, moreover, included these assessments in their routine clinical work. While we agree that this procedure is better than just using one's subjective clinical hunch, we do not think that one can dismiss the possibility that they were missing some of their patient's illnesses by not using one of the standardised case finding research interviews. Indeed, the very high threshold score advocated in their letter would be consistent with this possibility.

Finally, we agree with Dr Boardman that it is now necessary to study whether the detection of such disorders is really helpful to the patient. We know from recent American research that merely informing a family doctor that a patient has a high general health questionnaire score does no good¹: it is necessary for the doctor to do something with the extra information.² But what should he do and for whom? We think it likely that severe depressive states would benefit from detection and treatment, but we lack information about the minor disorders with mixtures of depression and anxiety.

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1 Hoepfer E, Nycz G, Kessler L, Burke J, Pierce W. The usefulness of screening for mental illness. *Lancet* 1984;i:33-5.

2 Johnstone A, Goldberg D. Psychiatric screening in general practice. *Lancet* 1976;i:605-8.

*.*This correspondence is now closed.—ED, *BMJ*.

BMX bike injuries

SIR,—It is disturbing to note the epidemic of injuries to BMX bike riders that is being experienced in England (13 October, p 956 and p 960). Since the first reports in Australia in 1982, injuries have continued to mount.^{1 2} A register of all trivial bicycle accidents in which ambulance transport was not required has been kept over six months at the Adelaide Children's Hospital in South Australia. This showed 135 cases of important injury requiring treatment, of which 55% occurred on conventional bicycles, 36% on BMX bikes, and 9% on motor bikes. Whereas conventional bicycle accidents usually occurred on public roads, the BMX accidents were associated with racing and jumping—often on specially built tracks.

In contradistinction to Dr Cynthia Illingworth's experience, a striking difference existed in the pattern of injury received. While abrasions, fractures, and head injuries were sustained on conventional bikes, the BMX injuries were predominantly abdominal. These injuries are often not immediately clinically evident and presentation to hospital is delayed. Despite the simple nature of the accident—namely, the handlebar impaling the abdomen—the resultant injuries were serious, including ruptured liver and spleen, pancreatitis, duodenal haematomas, and bowel perforation.

If these injuries are more common than the present few reports suggest then more should be done to warn unsuspecting parents.

Indeed, a change in the BMX bike design to prevent the wide handlebars turning through 90° and thereby being in direct line with the abdomen—as is the case with most conventional bikes—may be sensible.

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- 1 Sparnon T, Moretti K, Sach RP. BMX handlebar—A threat to manhood? *Med J Aust* 1982;ii:587-8.
- 2 Burk AM. A serious BMX bike injury. *Med J Aust* 1982;ii:283.

SIR,—We also have found an increase in the severity of bicycle injuries related to the BMX bicycle as against the ordinary bicycle. In particular we have seen several mandibular condyle fractures¹ and some severe facial lacerations. The children injured on BMX bikes were younger on average than the children injured on ordinary bicycles. So far none of the injured children we have been asked to see with BMX bicycle injuries has worn protective clothing, gloves, helmet, etc. Most accidents related to stunts and did not involve a third party. I believe it would be in the industry's interest to ensure that parents know of the hazards and that BMX bicycles should be sold with protective clothing included.

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- 1 Adlam DM. Mandibular fractures and the BMX bicycle. *Br Dent J* 1984;156:430.

SIR,—I have recently managed a life threatening injury due to the intrinsic mechanical failure of a BMX bike, which has not previously been reported.

A 13 year old boy who had been riding his BMX bike for three years was cycling normally along a public road when the front forks spontaneously sheared just above the level of the fork crown. He was thrown over the front of the bike and sustained a point injury to his abdomen from one end of the loose handlebars. He also sustained minor limb abrasions.

He was admitted to the surgical wards of the Vale of Leven Hospital, Dunbartonshire, within two hours of injury and was found to have symptoms and signs of left sided peritonism—maximal in the left upper quadrant. The only external sign of injury was an abrasion in the left iliac fossa. An erect abdominal x-ray examination showed a little free gas below the right hemidiaphragm.

At laparotomy he had free fluid soiling the peritoneal cavity, and there were two 2.5 cm diameter perforations of the upper third of the jejunum 12 cm apart. One was on the anti-mesenteric border and the other on the mesenteric border associated with a mesenteric haematoma. A 16 cm length of small bowel was resected, the bowel was reanastomosed, and a tetracycline lavage was performed. The patient made an uneventful recovery and was discharged on the ninth postoperative day.

The bicycle itself had been guaranteed for 10 years, but examination showed that the tube had fractured circumferentially at a level where two internal steel pins held the fork tube within the fork crown. Presumably this had become weakened due to repeated stress from stunts on tarmac and concrete surfaces which the bike was not designed to withstand.

Small bowel rupture occurs in 5-10% of cases of severe blunt abdominal trauma and carries a high mortality if there are multiple

injuries or the diagnosis is delayed—as is often the case.¹ It is uncommon to have an isolated injury of double jejunal perforation,² and most are usually small enough to be oversewn.¹ In children rupture of the gastrointestinal tract is commonly associated with bicycle accidents, and it has been observed that these may be caused by point injuries from the end of a handlebar.³

Without doubt stricter safety and design standards are required to reduce the risk of mechanical failure in some models of BMX bikes, although it is likely that the best bikes on the market are adequately safe at present. A publicity campaign to make parents and children aware of the dangers of stunt riding outside recognised BMX tracks and without adequate protective gear would also be highly desirable. Finally, another possibility could be the introduction of a certificate of riding competence, perhaps issued by BMX organisations, since many of the injuries are occurring in inexperienced riders.

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- 1 Robbs JV, Moore SW, Pillay SP. Blunt abdominal trauma with jejunal injury: A review. *J Trauma* 1980;20:308-11.
- 2 Geoghan T, Brush BE. The mechanism of intestinal perforation from non-penetrating abdominal trauma. *Arch Surg* 1956;73:455-64.
- 3 Dickinson SJ, Shaw A, Santulli TV. Rupture of the gastrointestinal tract in children by blunt trauma. *Surg Gynecol Obstet* 1970;130:655-7.

SIR,—We have found BMX bike injuries to be an important problem in our area over the last year. We have reviewed the patients with injuries attributable to BMX bikes who required admission under one surgical team in a one in three on call rota over six months finishing September 1984.

Thirty four children required admission, and 28 had head injuries with a suspected or proved episode of loss of consciousness. There were no skull fractures on radiological examination. In five cases there were important facial injuries, either cuts or grazes that required further attention. Five cases were admitted because of abdominal trauma, and we thought that further investigation and observation were warranted.

In four of these cases no important pathology was detected, but in one 8 year old boy clinical examination showed a haemotoma in the left upper abdominal quadrant, although there was no break of the skin in this area. Subsequently he developed signs of peritonitis and a laparotomy was performed. This showed a partial rupture of the duodenojejunal flexure with a traumatic rupture of the left rectus abdominal muscle and rectus sheath. In this case the injury had been inflicted by the handlebars of a friend's bike; they had collided while carrying out a stunt riding down a hill. He made an uneventful recovery.

Most patients in this group were aged 5-12 (29 out of 34), and none was older than 16. In addition, we found that all of these children had been doing some sort of stunt or "reckless manoeuvre" when the injury happened.

These results relate to a select group of patients and obviously take no account of the number of others seen in the casualty department with less severe injuries and orthopaedic problems. The more severe injuries appear to be related to participation in stunts, which compares with the 40% incidence of stunt

related injuries in Dr Cynthia Illingworth's paper.

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Motorcycling injuries in children

SIR,—We share the concern of Mr K Sherman and Dr J Mackinnon (6 October, p 877) and Mr M A Mason (p 854) over motorcycling injuries in children, particularly in so far as they affect younger children. As Court put it, accidents "are the result of the encounter of developmentally immature children with a dangerous environment," but there is a world of difference between the physical capabilities and judgment of a 5 or 6 year old and those of an adolescent of 14 or 15.¹ Mr Sherman and Dr Mackinnon comment on the "immature skeletons" of the riders, but it is the overall developmental immaturity which is of great importance in producing an accident.

Mr Mason is not correct in saying that "the details that are available relate only to motorcycle accidents occurring on the public highway": short reports by Stilwell in 1978² and Place in 1979³ both looked at scrambling accidents off the roads. Stilwell included accidents in both officially supervised and unsupervised races, while Place's series was of children injured in official races only. Both these authors felt that the injuries were acceptable both in frequency and severity, but in correspondence after Place's paper we disagreed strongly with this and commented "that children under the age of 12 are incapable of making the correct judgments that these circumstances necessitate."⁴ Place later agreed that "children of this age are not suited physically or mentally to take part in such sports."⁵

It is the children under 13 or so who concern us most. Riding some (but not all) motorcycles demands the simultaneous and precise use of all four limbs to operate accelerator, clutch, brake, and gears. This has to be done at the same time as judging speed and distance, and it must be done reliably. In our opinion, children of 6-11 are developmentally incapable of doing this consistently. The increases in physical strength and coordination that occur with puberty result in a clear cut change over the next few years so that the well developed and coordinate 14 or 15 year old presents a very different range of abilities and is entitled to test himself out.

There appear to be two groups of factors which have led to the use of motorcycles by very young children. The first relates to the parents. Parents' misunderstanding of their children's abilities to cope with traffic is well recognised—Sadler's work showing that 13% of mothers of children aged only 2 years expect them to be able to cross a main road by themselves in safety is a supreme example⁶—and there is a lack of appreciation of the risks that they expose their children to on motorcycles. In addition, as Place pointed out, parents are encouraging the child "not for his enjoyment but for the feelings of displaced pleasure that they experience." We have heard of a father saying to his crying 6 year old "get back on that bike and don't be so soft."

The second factor is the attitude of the motorcycle manufacturers. We think it reprehensible to make machines specially for young children, and the industry must know the results of the use of these machines. (At the other end of the scale one wonders why motorcycles (or cars) capable of 130 mph (210 kph) are sold when these speeds are illegal.)

What can be done? It may be that more data will be needed. We know of children with severe head injuries (with and without brain damage), gas gangrene, fractured facial bones, and severe leg injuries, but comprehensive data which give information about age, injury, type, and severity, together with place and type of activity are also