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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Design of motor-cycle crash helmets

SIR,—Reading your leading article on this subject (11 June, p 1491), it would appear that you are advocating the use of the full-face helmet for motor-cyclists. The support for this type of helmet seems to be based on the decreased incidence of facial injury due to the presence of a bar across the lower part of the face. This bar was originally built in to the helmet not to protect the face but to increase the stability of the cranial shell.

As chief honorary medical officer to the British Motor Cycle Racing Club for 30 years, and now chairman of the medical committee of the Auto-Cycle Union, I was involved six years ago in trying to get these helmets banned for racing use, as they already were in two European countries and a State of Australia. My main contention was that the weight of the full-face helmet was almost double that of the jet type helmet and the diameter greater, thereby increasing the forces

transmitted to the cervical spine, particularly rotation. The ban was not imposed for lack of evidence. Since then I have personally treated five motor-cycle racers with neck injuries received while wearing full-face helmets, four of these being fatal, and have knowledge of another fatal neck injury only two weeks ago. I think it is likely that many deaths attributed to head injuries are, in reality, high cervical injuries. A further hazard of these helmets is inhalation of vomit which cannot readily escape.

I feel that overprotection of one part of the body to the detriment of another should be carefully considered before full approval is given to articles of protective clothing for motor-cycles. I will continue to wear a jet type helmet.

GORDON HADFIELD

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Congenital dislocation of the hip

SIR,—I fear that your leading article (21 May, p 1303) is likely to increase the confusion that exists regarding "clicks" and "clunks" and their significance. You suggest that hips which subluxate at birth are "clicks" and do not require treatment. You support your view by reference to a short abstract, which indeed you reproduce almost verbatim, omitting only the critical finding—namely, that the author reported a 15.9% incidence of hip subluxation among the 866 infants he examined at birth.¹ You also omit the last three lines of the abstract, which comment: "In the discussion it was suggested that this high figure might be caused by misrepresentation of clicks which

are easily elicited in the newborn on manipulating the hips, but which do not necessarily indicate dislocation or subluxation."

My own experience, like that of Barlow² and others, suggests that the incidence of hips which "clunk" or subluxate at birth ("Ortolani positive") in this country is approximately 1.5%. Clicking hips are commonplace and should be ignored. Hips which "clunk" are abnormal³ and in my view should be treated at once. It is true that the majority of such hips become stable without treatment. However, some 10% will progress to full dislocation, while a similar proportion of the hips that become stable will be shallow and/or

dysplastic, and may either dislocate later on or eventually become osteoarthritic. Nor do I know of any way of predicting at birth the outcome in any individual case. Furthermore, once the legs extend after birth simple subluxability may progress to full dislocation with intumed limbus within a matter of weeks.

Limitation of abduction, which is an uncommon sign at birth, becomes the rule rather than the exception by the age of 3 months. This greatly increases the danger of ischaemic necrosis of the femoral head in association with abduction splinting.⁴ The leading article implies that this serious complication may arise, albeit infrequently, from simple treatment in the neonatal period. It is worth noting that all the cases reported by Gore⁵ were treated by plaster cast after the neonatal period, the average age of commencing treatment being 8 months. In contrast, Fredensborg⁶ states that in Malmö between 1956 and 1973 no such complication occurred among 510 infants treated from birth with a von Rosen splint. My own experience over the last 18 years has been the same.

My practice is as follows. All infants are examined by a paediatrician on the first day of life. Suspected hip abnormalities are checked at once by a senior member of the staff. When CDH is present, treatment is commenced at once using the Aberdeen⁷ or von Rosen⁸ splint for 6 to 12 weeks depending on whether the hip is subluxatable or dislocated at birth. All infants are followed up with regular radiological checks until at least 5 years old. With the help of Dr Rosemary Evans and the co-operation of Mr Peter Witheroe I am currently reviewing the last 300 cases. There have been no significant complications, and the end results have been excellent. Among over 20 000 infants screened since 1969 there have been four diagnoses of CDH after the neonatal period, an incidence of 0.2/1000. All these particular infants were screened at birth by junior doctors who had just joined the staff, two of them being temporary locum tenens. It seems very likely