The perilous skateboard

SIR,—I am intrigued by the conflicting attitudes of your two recent correspondents on this subject, Dr A R Rogers (15 October, p 1026) and Dr S P Glascoe (5 November, p 1222). The one berates the BBC programme "Nationwide" for encouraging skateboarding and implies that the medical profession should be campaigning against "this dangerous sport." The other maintains that injuries from this pastime are only minor and relatively infrequent, and that skateboarding is making a positive contribution to teenage recreation.

Reviewing the skateboard injuries seen in the accident and emergency department of this hospital reveals that the highest incidence was one a day during August, but it dropped to 23 in September and was only two a week in October. For a popular teenage sport overall this is not a high incidence, but what is disturbing is the large number of fractures in these patients. For all sports injuries our incidence of fractures is 14.8%, but for skateboard injuries it is 22.6%, and these are mostly forearm and wrist fractures. To fall from a skateboard on to the outstretched hands at the modest speed of only 15 mph (24 kph) can result in a forearm fracture. To avoid such an injury the skateboarder should not only wear helmet and padding but also learn to roll as he falls rather than taking the whole impact on his outstretched hands.

Whatever the attitude of the medical profession should be to this sport, there seems little doubt that we shall see a temporary epidemic of skateboard injuries in the last week of the year when Father Christmas has distributed the thousands of new skateboards that are now in production.

D H WILSON

Accident and Emergency Department,
General Infirmary,
Leeds

SIR,—I cannot let Dr S P Glascoe (5 November, p 1222) dismiss his responsibilities so easily. I have recently made my views on this new sport clear (*Daily Telegraph*, 1 November, *Express and Echo*, 26 October, "Westward Report," ITV 3 November, etc) and have been amazed at the reaction nationally and locally. These views, albeit rather overdramatically publicised by the press, are that any sport has risks and that participants should be fully aware of these when they take it up. In the case of skateboards the media and commercial interests have not, understandably in the latter case, given the information that will enable participants or their parents to make their choice between declining to indulge in sidewalk-surfing and perhaps, if they do indulge, of suffering the significant risk of injury which, in a small minority, may maim. It has been my purpose in the south-west to make public the statistics that have been freely available to doctors for some time.¹⁻⁴

It is not necessary to promote the negative in these matters, and I have been instrumental in bringing together, for instance, the Sports Council and a group of responsible local entrepreneurs who plan a track in Exeter and in drawing the attention of a very large number of parents to the merits of investing in a properly designed fibreglass board rather than one of the supermarkets' cheap imitations that even quite advanced skaters would have difficulty in controlling and particularly in stopping. Here, Dr Glascoe, is where cars and even children's cycles differ: they have brakes!

In the south-west the producer of "Westward Report" found 100 recorded skateboard injuries during October, almost entirely among the 5-15-year age group—the surfers who take up skateboarding in the winter are more expert and wear more protective clothing than the youngsters. The experience of orthopaedic surgeons in Hawaii and Southern California clearly shows us that once skateboards catch on the sport takes off in a big way, and it might be unwise to ignore the implications for casualty and paediatric departments or to pretend that an epiphyseal injury in a child has no more significance than a tap fracture at soccer or having your ear bitten by a Newport prop forward.

CHRISTOPHER D JEFFERISS

Exeter

- ¹ Jacobs, R A, and Keller, E L, *Pediatrics*, 1977, **59**, 939.
- ² Atienza, F, and Sia, C, *Pediatrics*, 1976, **57**, 793.
- ³ National Centre for Health, US Department of Health, Education and Welfare, 1975 statistics.
- ⁴ National Electronic Injury Surveillance System, United States Consumer Product Safety Commission.

SIR,—Dr S P Glascoe (5 November, p 1222) says, "Skateboards are like cars: they are not dangerous, but the people who use them may be."

Like cars, they are lethal weapons and their use should be legally restricted to tracks or areas specially provided. At present as ridden in our streets they are indeed perilous—for the ordinary pedestrian.

MARGARET I LITTLE

Sevenoaks, Kent

Primary excision of brain abscess

SIR,—Mr A R Choudhury and his colleagues (29 October, p 1119) are to be congratulated on treating 16 consecutive cases of brain abscess by primary excision with only one death. Unfortunately the data contained in their paper are quite inadequate for the didactic statement that "immediate primary excision is therefore the treatment of choice."

The long-standing controversy between the proponents of aspiration and those of excision relates only to supratentorial abscess, and the authors report only 14 patients (with one death) with such lesions. Conclusions about methods of treatment can never be drawn from such small numbers. Only two patients were examined by computerised axial tomography (EMI scan), but this method of examination has now virtually replaced other radiological methods in well-equipped neurosurgical departments. The use of sequential scans now allows much more accurate assessment of size of abscess and extent of brain oedema, and my own recent experience has been that patients can often be managed safely after initial aspiration without either repeated needling or craniotomy. Furthermore the results of recent excellent microbiological work¹⁻² have contributed to this trend.

It is surprising that, having admitted that "the incidence of epilepsy cannot be accurately estimated in this series because of the limited follow-up," the authors in the same paragraph claim "a very low incidence compared with that in other series" and do not refer to the most valuable and recent paper on this topic,³ which noted a mean interval of 3.3 years between surgery and onset of epilepsy; the incidence of epilepsy was as high after excision as after repeated aspiration.

When extremely divergent views about methods of treatment exist the truth is likely to lie somewhere between the two. It is unfortunate when one extreme view is reiterated, particularly on inadequate evidence and in conditions which are only partly relevant to current neurosurgical and neuroradiological practice.

J S GARFIELD

Wessex Neurological Centre,
Southampton General Hospital,
Southampton

¹ de Louvois, J, et al, *British Medical Journal*, 1977, **2**, 981.

² de Louvois, J, et al, *British Medical Journal*, 1977, **2**, 985.

³ Legg, N J, et al, *Brain*, 1973, **96**, 259.

SIR,—As Mr A R Choudhury and his colleagues state (29 October, p 1119), the mortality of brain abscess is indeed related to its space-occupying effect. The only absolute statement that follows regarding treatment is that the raised intracranial pressure should be relieved by some form of surgery while the patient is neurologically alert.¹ The choice of this surgical procedure will vary from patient to patient.

Primary complete excision where possible is widely accepted as the treatment of choice for cerebellar abscesses.² In the case of supratentorial abscesses it is sterile to argue in favour of one method alone because there is a place for both an aspiration drainage technique and excision of the whole abscess.³⁻⁴ Complete excision may be the ideal, but this cannot by any means always be realised.⁵ Abscesses that are multiple, massive, or deeply situated cannot be excised, completely or otherwise, without severe morbidity.

A J KEOGH

Department of Neurological Surgery,
Royal Infirmary,
Sheffield

¹ Keogh, A J, and Barrington, N A. In preparation.

² Shaw, M D M, and Russell, J A, *Journal of Neurology, Neurosurgery and Psychiatry*, 1975, **38**, 439.

³ Cavey, M E, Chou, S N, and French, I A, *Journal of Neurosurgery*, 1972, **36**, 1.

⁴ Jefferson, A A, and Keogh, A J, *Quarterly Journal of Medicine*, 1977, **46**, 389.

⁵ Samson, D S, and Clark, K, *American Journal of Medicine*, 1973, **54**, 201.

Treating dissenters

SIR,—Dr Edward Hare (29 October, p 1136) suggests that our response to Soviet psychiatrist colleagues who serve the KGB by ruling mentally healthy dissenters insane should be one of "sympathy rather than abhorrence." We are puzzled that he should reach this conclusion after reading our book, *Russia's Political Hospitals*, as we document there in detail the reasons why these psychiatrists cannot be considered colleagues.

In chapter 8 we distinguish carefully between three groups of Soviet psychiatrists vis-à-vis the abuses: a core group of several dozen doctors who occupy powerful positions and who have undoubtedly prostituted themselves; the vast majority of average psychiatrists who try to evade the KGB efforts to involve them in unethical practices; and a minuscule group which actively opposes the abuses.

The core-group psychiatrists have for several years co-operated fully with the KGB and defended Soviet psychiatry against Western allegations. We record numerous instances of their blatant unethical conduct and deceitfulness in both spheres. Dr Hare need only read our account of a meeting held in 1973

at the Serbsky Institute of Forensic Psychiatry—at which visiting Western psychiatrists were manipulated in an effort to whitewash Soviet psychiatry (see pp 303-320)—to gain an impression of the devious tactics resorted to by the core group. No informed Western psychiatrists could possibly be sympathetic to this group. We should, however, make every effort to support those of our colleagues—the majority of Soviet psychiatrists—who find the political misuse of their profession as abhorrent as we do, and particularly the courageous few who are being punished for exercising their professional conscience.

We are also puzzled by Dr Hare's comments on the dissenters. His suggestion that they seek martyrdom and obsessively persist in their campaigns demeans the whole human rights movement in the USSR. All the dissenters we have interviewed were more than aware of the risks they were taking, including, ironically, the possibility of internment in a mental hospital. Certainly none of them relished this possibility!

We would entirely agree with Dr Hare's final comment that there is a need for British psychiatrists to look into their own backyard. However, ethical issues in medicine transcend geographical boundaries and a concern about our own practices and those of our colleagues elsewhere are not mutually exclusive.

S BLOCH

Department of Psychiatry,
University of Oxford

P B REDDAWAY

Department of Political Science,
London School of Economics

Science, race, and intelligence

SIR,—The question of race and intelligence is not as simple as would appear from your leading article (22 October, p 1040). It would be better were we able to research and discuss the problem in an emotionally neutral scientific environment, but nowadays this is not possible even in the scientific press. There are too many people eager to distort the facts for their own political ends. May I draw your attention to the following facts, which you appear not to have considered?

(1) The Black man in a predominantly White society sees himself in an uncertain, even overtly hostile, environment. As intelligence is commonly equated with worth it is not surprising that he reacts to the suggestion that he and his children may be innately less intelligent than their White neighbours.

(2) When race and intelligence are discussed the assumption always seems to be that there is a clear distinction between Blacks and Whites. Blacks are people who are seen to be not White. The mixed-raced child is classified as Black and accepted by both ethnic groups as such; thus White is equated with purity and Black with impurity.

(3) Leaving aside this philosophical consideration, the prejudices of many researchers lead them to lump together all the non-White people into the Black group. It is a matter of history and common observation that the Blacks of the West Indies and America are ethnically heterogeneous people. The genetic mixture of the West Indian Blacks is mainly of African, European, and Indian. It is possible to find an average intelligence and draw a normal distribution curve of intelligence in these people, but the meaning and application are doubtful. Even were it provable that our

Black population are less intelligent than the White majority this fact would be meaningless when faced with a child who could be "95% White" and yet still look very black.

It may be that we shall one day answer the question, but it behoves researchers to take heed of the feelings of the people they are investigating. Until we have an unequivocal answer uninformed speculation in public is mischievous. Kite-flying is a fine occupation for the scientist, but it is dangerous in stormy weather.

BRIAN SILK

Department of Paediatrics,
Kettering and District General
Hospital,
Kettering, Northants

Incidence and mortality of acute pancreatitis

SIR,—Your leading article (22 October, p 1043) gave valuable emphasis to the growing weight of evidence linking acute pancreatitis with a wide variety of drugs. However, I feel that the quoted incidence of 2500 people a year in Britain (± 46 cases per million) with 500 deaths (20% mortality rate) may present a somewhat pessimistic impression of the disease.

The incidence of acute pancreatitis probably reflects the thoroughness with which the disease is sought as well as the criteria which are accepted to define its existence. Using conventionally acceptable criteria for diagnosis such as a consistent clinical presentation and course, a serum amylase level of at least 1000 Somogyi units, or characteristic findings at laparotomy or post-mortem examination, 35 cases of acute pancreatitis were treated in this hospital during 1976. This is an approximate incidence of 110 cases per million of population. As there is no evidence to suggest that the disease is more common in Leeds than elsewhere, this would indicate that some 6000 cases per year might be expected in Great Britain. The mortality rate in this hospital, in common with several other centres in Great Britain, is at present less than 10%.

A simple mathematical calculation might lead to the conclusion that we are doubling the incidence by uncovering many mild cases and thus apparently achieving a halved mortality. Although this may be true to some extent I believe that a thorough screening of all acute admissions enables many cases to be diagnosed and treated early enough in the course of the disease to achieve a real reduction in mortality.

M J McMAHON

University Department of Surgery,
General Infirmary,
Leeds

SIR,—The purpose of focusing attention on the problem of iatrogenic pancreatitis, in particular that associated with certain drugs, was admirably achieved by your recent leading article (22 October, p 1043). However, the figures quoted in the introductory section regarding the incidence and mortality of acute pancreatitis warrant comment. The total number of patients suffering from acute pancreatitis was quoted as about 2500 per annum in Britain. This figure was presumably reached by simple arithmetic reckoning, assuming the Bristol¹ and Nottingham² incidence of 50 per million of the population to be representative for the whole country. It is not justifiable to present these figures as national statistics without clearly stating that an extrapolation

from regional surveys has been performed. There are very few areas of the country in which even short-term prospective statistics are available, but in one area where almost six years of continuous prospective analysis has been performed the incidence is at least twice the suggested national average.^{3,4}

The quoted mortality rate of 20% takes little cognisance of more recent evidence from prospective studies of over 630 patients, indicating a much lower mortality from acute pancreatitis.³⁻⁵ A study of 213 patients reported two years ago revealed a mortality rate of 11%.³ and since that time the multi-centre MRC study has confirmed that figure with an identical mortality rate in 257 patients.⁵ One further study of 161 patients has reported an even lower mortality rate of under 9%.⁴ The time has now surely come to lay aside the concept of mortality rates in the region of 20% being part of acceptable clinical practice in this country.

C W IMRIE

Department of General Surgery,
Royal Infirmary,
Glasgow

¹ Trapnell, J E, and Duncan, E H L, *British Medical Journal*, 1975, **1**, 179.

² Bourke, J B, *Lancet*, 1975, **2**, 967.

³ Imrie, C W, and Blumgart, L H, *Bulletin de la Société Internationale de Chirurgie*, 1975, **34**, 601.

⁴ Imrie, C W, et al, *British Society of Gastroenterology Meeting* (York), 1977.

⁵ Cox, A G, et al, *Lancet*, 1977, **2**, 632.

Role of the hospital in primary paediatric care

SIR,—Dr A J R Waterston (15 October, p 1021) has missed the main point of my lecture (24 September, p 787) when he suggests that I am "reverting to the 'disease palace' for the cure of all ills." This is the antithesis of my real concern to improve the standard of general practice in large urban areas with their declining living standards. I believe that in the immediate future this can be achieved only by the hospital going out into the community to give assistance and I have suggested a way by which this might be done. Dr Waterston has given undue emphasis to the "ill child presenting at the door," implying that this would be a new situation. As I emphasised, this already happens and is a considerable burden and responsibility for departments which have not the establishment to handle these problems. By creating a better relationship and communication with the general practitioners in these areas and with an intelligent use of child health visitors and liaison health visitors it will be easier and safer to return these children to their homes and also to implement a home nursing scheme, as mentioned in my lecture.

In no way did I propose that this would be a casualty-based service. It is clearly stated that the project would be based in the paediatric department and the children's section of the accident and emergency department of the hospital concerned, and I suggested that the pilot trial should be based on the three major children's units in Manchester (two of them being children's hospitals). Again, there is nothing to indicate that I am trying to get extra casualty sessions for general practitioners. I stated that "one or more of the practitioners on duty could be on call at the hospital, and this night and weekend duty could be shared by the general practitioners, child health practitioners who had agreed to