shift worked is "only" 19 hours but this occurs at the end of the week of nights, as the third of three long shifts (16, 16, and 19 hours), and is particularly exhausting.

Having moved from Southmead to a 1 in 3 obstetric post with a similar out of hours commitment, I find that the traditional rota is less tiring, since there are two clear weekends to recuperate. The system would best be improved, however, by emulating most anaesthetic rotas: after a night on call the senior house officer has the next day off. A busy night would be much easier to endure if some sleep was guaranteed the next morning.

Although the shift system described has some advantages it has failed to achieve fully its original purpose of improving both the care of the babies and the working patterns of the senior house officers.

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The need to make rugby safer

SIR,—As an orthopaedic surgeon and a former first class rugby prop forward I think that Dr H C Burry's and Mr C J Calcinai's article (16 January, p 149) has no great message for rugby football. The paper which they quote seems to be the only scientifically followed epidemiological research on injuries from playing rugby.¹ In Wales the incidence of serious cervical cord injuries has risen to a steady level of two or three a year. Recent changes in the front row scrummaging rules have had no effect on this, and scrummaging injuries account for 44% of the total. Two suggestions for immediate action are the banning of the practice of "popping" opposing front row props out of the scrum and education of the second row forwards about the danger of continuing forward momentum in the collapsed or lifted scrum.

I was perturbed by the comments of Messrs D A D MacLeod and P H Pattison (13 February, p 498). There is no place for complacency in this disturbing situation. Pressure on the flexed cervical spine is dangerous and must be minimised if we are to make rugby safer.

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1 Williams P, McKibbin B. Unstable cervical spine injuries in rugby football: a 20 year review. *Injury* 1987;18:329-32.

Tardive dyskinesia

SIR,—Dr Thomas Barnes (16 January, p 150) states unequivocally that tardive dyskinesia is a "disorder of movement caused by dopamine antagonist drugs," ignoring a detailed historical literature that suggests this is not true. Nineteenth century descriptions of chronic psychotic illness, reflecting Kraepelin's classic delineation of dementia praecox,¹ constantly refer to grimacing and gesticulations as typical features. More recent work by Brandon *et al.*,² Owens *et al.*,³ and Waddington⁴ has emphasised the presence of tardive dyskinesia among psychotic patients never treated with dopamine blocking drugs. My own research into Victorian casebooks supports such findings, all of which logically point to tardive dyskinesia as resulting primarily from the intrinsic disease process itself, mediated by dopamine antagonists.

The importance of refuting Dr Barnes's statement lies in the need to understand, and appropriately research, neurochemical aspects of

psychotic illness, as well as in the possible malpractice suits that might ensue, in these increasingly legalistic times, from patients with tardive dyskinesia making claims against those treating them. It also underlines the fundamental necessity of a historical perspective.

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- 1 Kraepelin E. *Lectures in clinical psychiatry* (trans Johnstone T). 3rd ed. London: Ballière, Tindall and Cox, 1913.
- 2 Brandon S, McClelland HA, Protheroe C. A study of facial dyskinesia in a mental hospital population. *Br J Psychiatry* 1971;118:171-84.
- 3 Owens DGC, Johnstone EC, Frith CD. Spontaneous involuntary disorders of movement. *Arch Gen Psychiatry* 1982;39:452-61.
- 4 Waddington JL. Tardive dyskinesia in schizophrenia and other disorders: associations with ageing, cognitive dysfunction and structural brain pathology in relation to neuroleptic exposure. *Human Psychopharmacology* 1987;2:11-22.

Charging patients for eye tests

SIR,—We entirely support Dr John Yudkin's plea (2 January, p 64) for the free eye test to remain and take issue with the subsequent correspondence from Messrs Smith, Scott, and Flanagan (23 January, p 290).

We participate in a cooperative system of diabetic care in Newham in which one of us (PK) sits with local general practitioners in diabetic clinics held in their surgeries. This system of care has also sought the help of optometrists for detecting diabetic eye disease. Since the publication of Dr Yudkin's letter four patients have been referred by optometrists with a suspected diagnosis of diabetes mellitus, two with incidental findings of diabetic retinopathy and two because of a recent deterioration in vision due to refractive changes. All of these patients had attended the optometrists for an eye test, but we accept that the optometrists were alerted because of the local interest in diabetes. We agree that general practitioners should screen the eyes of their own diabetics including dilatation of the fundi; indeed, we ensure that this is regularly performed in our own shared care clinics. In these circumstances, however, the examination is done in a designated surgery; patients are warned not to drive to the surgery, and a diabetologist is present to help instruct the general practitioner. We suspect that the situation is not so ideal in most practices. For this reason the participation of optometrists in a system of free eye tests will, at the very least, widen the possibility of early detection of diabetic eye disease.

Any payment levied on patients will deter those who are most at risk.

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SIR,—I agree with Mr Redmond Smith (23 January, p 290) and Mr Rolf Black (6 February, p 431), who suggest making greater use of ophthalmic medical practitioners to relieve the pressure on the hospital eye service.

The "medical eye centre" (which ironically was created to cope with the rush for free eye tests in the early days of the NHS) never developed its full potential. The medical aspect was overshadowed by the retail aspect of the business houses who endowed these centres, and for some obscure reason the government never permitted ophthalmic medical practitioners to prescribe even eye drops on NHS forms. Nevertheless, some medical eye centres still provide a valuable neighbourhood service to both general practitioners and the public.

Many, like myself, must be able to recall picking up cases of ocular or systemic disease whose morbidity would have been dangerously increased by delay in treatment.

Now that the ethical restrictions on the optical profession have been relaxed I fear that the patient has become a "customer" and the consulting room a small part of a boutique selling fashion frames. To whom can the family doctor send patients with indefinite symptoms and suspicious signs which could be resolved by slit lamp examination, gonioscopy, applanation, or field testing at a medical eye centre but for which they might have to wait months at a hospital?

Is there any reason—apart from penny pinching—why the ophthalmic medical practitioner should not be contracted to examine patients either on a sessional or per caput basis at a health centre or as part of a general practice?

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

Inappropriate dental care in casualty departments

SIR,—There is serious concern in this unit about incorrect treatment for children and adolescents who have knocked out permanent incisor teeth and who have been taken to casualty departments in district general hospitals.

This was shown recently in two cases, one in an 8 year old girl and the other in a boy of 13. Both children had had upper permanent central incisor teeth knocked out during the evening. In each case the patients had been seen by a casualty officer at hospital within 30 minutes of the accident. After examination the parents were advised that nothing could be done and were told to take their child to a dentist the next day. In neither case was the hospital dentist on duty called to see the patient. When the children were seen the next morning it was too long after the accident to replant the teeth, and they are now required to conceal the unsightly gap by wearing a denture. This is an extremely unfortunate and avoidable outcome of this type of accident in a young child.

In children and adolescents a tooth that is replanted into its socket within 30 minutes of being knocked out has a 90% chance of reattaching itself to the bone and becoming fully functional. There is then a deterioration in prognosis, related to time after the accident, until it becomes poor after two hours and hopeless when several hours have elapsed.¹ Thus it is essential that the appropriate action is taken without delay.

When a child presents at the casualty department having knocked out a permanent incisor tooth the tooth should be immediately placed in physiological saline while the history and examination are conducted. No effort should be made to disinfect the tooth or scrub it clean. If the tooth is dirty it should be gently flushed with physiological saline to avoid damaging the delicate periodontal membrane on the root. If the tooth has not been brought to the hospital efforts should be made to retrieve it if this can be done expediently. The hospital dentist should be contacted and asked to attend the patient immediately. If there is likely to be any delay the casualty officer should replant the tooth as soon as possible and then get the patient to bite on a pad of gauze to hold the tooth in position. No anaesthetic is usually required for this operation and the blood clot should not be removed from the socket before replantation. An antibiotic should be prescribed and the need for tetanus vaccination