work for reasons similar to those described above. Once more, after pressure from the patients, we reached agreement with the health authority and the community health councils to have two short visiting spells each day—one in the afternoon and one in the early evening. The precise times and duration depend on the ward concerned.

We agree that the patient's needs are paramount but not the exclusive consideration. One patient's wishes should not be inflicted on other sick patients in neighbouring beds. The caring professions have a duty to tend their patients, but if this is constantly hindered by the excessive and prolonged presence of visitors we have a duty to consider where the priority lies.

BRIAN ALDERMAN

Arrowe Park Hospital,
Upton,
Wirral,
Merseyside L49 5PE

Case-control study of cutaneous malignant melanoma

SIR,—The abstract of the paper by Drs Dallas R English and Bruce K Armstrong on identifying people at high risk of cutaneous malignant melanoma (7 May, p 1285) is misleading in stating that "... time spent outdoors in summer from the age of 10 to 24 ... provided good discrimination between patients [with malignant melanoma] and controls. ..." In fact table I, which shows odds ratios for variables independently predicting risk of cutaneous malignant melanoma, and a small section in the results state that increasing exposure to sunlight between the ages of 10 and 24 was associated with a decreasing incidence of cutaneous malignant melanoma. It would therefore seem that increasing exposure to sunlight between the ages of 10 and 24 years has a protective effect on the development of cutaneous malignant melanoma.

This is an interesting finding, particularly in view of the large amounts of money currently spent by the Australian government on the "Slip, Slop, Slap" campaign aimed at children and discouraging prolonged exposure to sunlight. I was disappointed that Drs English and Armstrong chose not to discuss the implication of this important finding in their paper.

N S BROUGHTON

Department of Orthopaedics,
Luton and Dunstable Hospital,
Luton,
Bedfordshire LU4 0DZ

AUTHORS' REPLY.—The model we developed did provide good discrimination between patients with melanoma and controls. Mr Broughton seems to have inferred that an apparent protective effect of time spent outdoors cannot help distinguish patients from controls. In fact, whether the effect of an "exposure" is to increase or decrease the risk of developing the disease makes no difference to its contribution to the model's ability to discriminate. Time spent outdoors was not the only variable that decreased the risk of melanoma—arrival in Australia after the age of 10 had the same effect. For such factors people in high risk categories are those with the least amount of exposure.

With respect to Mr Broughton's comment about the implications of decreasing the risk of melanoma by increasing the time spent outdoors, we reiterate that the purpose of our paper was to determine whether it was possible to identify a group of people at high risk of melanoma, not to identify risk factors for melanoma. Our finding of a protective effect of increasing time spent outdoors was not new and has been discussed in more detail.¹

Although it seems that a reduction in exposure to the sun by Australians may increase the incidence of melanoma, our study also showed that arrival in Australia after the age of 10 was a strong independent predictor of a reduced risk of melanoma. The prevalence of naevi, which was the strongest risk factor for melanoma, was also reduced in these migrants. As most migrants to Australia come from countries that have less sun it is reasonable to assume that their lower risk is a result of less exposure to the sun early in childhood. Thus the "Slip, Slop, Slap" campaign directed at children should, if successful, reduce the incidence of melanoma.

In addition, the "Slip, Slop, Slap" campaign is directed primarily at the prevention of non-melanocytic skin cancer, which is the commonest cancer in Australia. Because of its high incidence non-melanocytic skin cancer is an important contributor to the use of medical and hospital resources. The indirect evidence from its distribution by age, sex, and site on the body and, to a lesser extent, its association with outdoor occupations would suggest that the incidence of non-melanocytic skin cancer increases with increasing total accumulated exposure to the sun and would be reduced by reducing exposure to the sun.

DALLAS ENGLISH
BRUCE ARMSTRONG

National Health and Medical Research Council,
Unit in Epidemiology and Preventive Medicine,
University Department of Medicine,
Queen Elizabeth II Medical Centre,
Nedlands 6009,
Western Australia

I Holman CDJ, Armstrong BK, Heenan PJ. Relationship of cutaneous malignant melanoma to individual sunlight exposure habits. *JNCI* 1986;76:403-14.

Diet and inequalities in health

SIR,—Dr J E Cade and others (14 May, p 1359) shows that, contrary to established wisdom, the fat content of diet in middle age is not related to the death rate from ischaemic heart disease. In fact, if the data from the three towns studied were taken in isolation they would suggest that a high fat diet conferred some protection.

The incidence of ischaemic heart disease in the towns studied rises the further north the town is located, and this supports the suggestion that environmental cold stress may play an important part in explaining the geographical differences in the distribution of ischaemic heart disease, since the degree of cold stress is dependent on absolute temperature, air movement, and dampness.¹

Although the social class distribution was similar in the three towns, the socioeconomic indices were worse in the two northern towns. Social class is usually closely related to socioeconomic indices, and the lower the social class the more likely it is that people are living in cold, damp housing. Low income, more common in the lower social classes, means that house repairs may have to be neglected, clothing may be of inferior quality and quantity, and energy intake may be marginal. Lower social class is also associated with smaller houses, poor insulation, and a higher number of people in each room. These factors increase the risk of damp.^{1,2}

The lower the social class, or the worse the socioeconomic indices, the greater the potential for exposure to cold stress, a relation which matches the known gradation of incidence of ischaemic heart disease through the social classes.^{3,4} One of the physiological responses to exposure to cold stress is a rise in the circulating concentrations of catecholamines,¹ and it has been suggested that these play a part in the aetiology of ischaemic heart disease.⁵ It seems probable that cold stress acts

through catecholamines, and a paper is being prepared which reviews the evidence for the role of cold stress in the aetiology of ischaemic heart disease.

E I LLOYD

Department of Anaesthetics,
Princess Margaret Rose Hospital,
Edinburgh EH10 7ED

- 1 Lloyd EL. *Hypothermia and cold stress*. London: Croom Helm, 1986:77-157.
- 2 Stephens DH. Sleeping snugly in cold damp bedrooms. *J R Soc Health* 1982;6:272-5.
- 3 Balarajan R, Yuen P, Machin D. Inequalities in health: changes in RHAs in the past decade. *Br Med J* 1987;294:1561-4.
- 4 Whitehead M. *The health divide: inequalities in health in the 1980s*. London: Health Education Council, 1987.
- 5 Carruthers ME. Aggression and atheroma. *Lancet* 1969;ii:1170-1.

Restraining infants in cars

SIR,—Dr M A Mason (14 May, p 1345) highlights the important problem of mortality and morbidity from road traffic accidents among infant car occupants. Unpublished Scottish Office statistics between 1981 and 1985 show that 288 (just over 7%) of the 3931 children injured while travelling by car were infants. Of these 75% were unrestrained.

We carried out a pilot study in Fife to see if the success of infant car seat loan schemes overseas could be repeated in Britain.¹ Our project was a success with 79% of the babies travelling regularly by car in the intervention population being carried in a rear facing infant car seat compared with only 8% of the control population. In the intervention group 93% of parents said that if they had another baby they would buy or hire an infant car seat. Interestingly, 82% of the mothers given a seat indicated that if one had not been provided they would have carried their baby in their arms or in a carrycot.

We urge health authorities and local government in other areas to give serious consideration to starting infant car seat loan schemes.

ERIC BAIJAL

Fife Health Board,
Glenrothes,
Fife KY7 5PB

1 Baijal E, Carter H, Jones IG, Walkingshaw IW. The role of infant car seats in road safety. *Journal of the Institute of Health Education* (in press).

Clinical carpal scaphoid injuries

SIR,—I thank Mr M Reichl and Dr M A Khan (23 April, p 1198) and Dr J J Langham-Brown (30 April, p 1259) for their comments on my and my colleagues' paper (19 March, p 825).

Traditional management by plaster cast for the clinical scaphoid injury is still practised in many hospitals throughout Britain. Awareness of the potential sequelae of scaphoid fractures has promoted this conservative approach.

Our study showed a low incidence of delayed radiological visualisation of scaphoid fractures (2%). We therefore concluded that the clinical scaphoid syndrome is a soft tissue injury and hence appropriate splintage should be sufficient; it is not the cause of the dangerous sequelae initially thought. As the *BMJ* has a wide distribution among junior and senior doctors we hoped that our article would give guidance to change from a policy of plaster cast management.

We also have reported the use of radionuclide bone imaging¹ and like Mr Reichl and Drs Khan and Langham-Brown would recommend it for diagnosis and management decisions. But not every hospital has an isotope department or immediate access to one. We would suggest that two