This week in BMJ

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Powerlines play no major part in the aetiology of childhood cancer

People who live close to overhead power lines and other high voltage installations are exposed to magnetic fields 10-20 times greater than average. Public concern has been caused by reports of an association between cancer in childhood and residence near power lines and high voltage installations. In this week's journal two separate groups have examined this association. On p 891 Olsen *et al* report the results of a population based case-control study of the risk of cancer in Danish children who had been exposed to magnetic fields from electricity transmission lines. A positive association was observed between all major types of childhood cancer combined and exposure to an average field strength of 0·3-0·4 μT or above. But at levels of ⩾0·25 μT no significant association was seen (odds ratio 1·5). They conclude that the epidemiological risk is uncertain and no evidence of biological link exists. Verkasalo *et al*, from Finland, also conclude that the magnetic fields produced by power lines are unlikely to increase the risk of childhood cancer (p 895). A cohort of 135000 children living in 1970-89 within 500 m of transmission power lines was followed up through the Finnish cancer registry to the age of 19. The observed number of cases (140) in the cohort was close to that expected (145), and significant increases in leukaemias, lymphomas, or overall cancer were found at any magnetic field level. Boys, but not girls, exposed to magnetic fields ⩾0·20 μT had a significant excess of nervous system tumours, but the authors think this is probably a chance finding. The results suggest that residential magnetic fields of power lines do not constitute a major public health problem regarding childhood cancer. The small numbers of cases of childhood cancer do not allow further conclusions about the risk of cancer in stronger magnetic fields.

Injury severity scores may produce inconsistencies

Trauma audit increasingly uses the combined trauma and injury severity score (TRISS) methodology developed in the United States to measure and compare trauma outcomes. On p 906 Zoltie and de Dombal, on behalf of the Yorkshire Trauma Audit Group, report some problems relating to observer variation in using the score. They highlight how the system can produce inconsistent results and show that only by better understanding can the system be used adequately. The combined trauma and injury severity scoring system remains the best method available for measuring trauma care but must be recognised for its potential inaccuracies when results from it are being analysed.

Either surgery or exercise improves rotator cuff disease

Rotator cuff disease of the shoulder is caused by overload of the tendons of the short rotator muscles; it is painful and results in reduced function of the joint. Treatment is commonly rest, analgesics, steroid injections, and remobilisation exercises, with the option of surgery to increase the acromial space. On p 899 Brox *et al* report the results of their randomised trial of arthroscopic surgery, supervised exercises, and placebo laser treatment in 125 patients with chronic disease resistant to standard drug treatment and physiotherapy. After six months both active treatments were significantly better than placebo in reducing pain and improving function, but neither was better than the other. The authors conclude that rotator cuff disease may be more cheaply managed by an exercise regimen supervised by physiotherapists but surgery remains an effective alternative.

"Hospital at home" treatment for fractured hip saves money

Patients with fractured neck of femur have in the past been seen as blocking beds on orthopaedic wards through an often lengthy rehabilitation period. In purchasing care for these elderly patients district health authorities need information on the optimal mix of inpatient and community services. On p 903 Hollingworth *et al* present the results of a study of 1104 patients admitted to a district hospital over a five year period, some with access to an early discharge scheme and others without such access. They conclude that the availability of an early rehabilitation scheme such as "hospital at home" within the community has potential economic benefits. However, these benefits may be dissipated unless careful attention is paid to the contract between purchaser and joint providers.

GPs want reaccreditation—but not too often

In 1992 the General Medical Services Committee survey of general practitioners in the United Kingdom suggested that doctors supported the idea of professional reaccreditation. A year later Sylvester conducted a survey among the 278 general practitioners of Cleveland to test this result and to determine doctors' views on how reaccreditation might be developed and carried out. The results, based on replies from 210 doctors, confirm professional support for reaccreditation (p 912). In particular the findings emphasise the importance of peer review in reaccreditation and development by the profession, and they underline the educational nature of reaccreditation.

Most people want to die at home

Increasingly people are dying in institutions, yet most would prefer to die at home. Much of the final year is spent at home, but most people are admitted to hospital to die. Should greater choice be available? On p 915 Thorpe reviews where people die, where they would choose to die, where they spend the last year of life, and the reasons for admission for terminal care. He sets out eight conditions which would enable more dying people to remain at home. The Countess Mountbatten House palliative care service in Southampton provides a successful example of reversing the national trend. The government is invited to take action in four ways to help people achieve their dying ambition.