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Correspondence

Letters to the Editor should not exceed 500 words.

Unnecessary X-rays?

SIR,—The letter from Dr. W. B. James, and others (10 January, p. 110) raises once again the problem of how to avoid unnecessary *x*-rays in accident cases. There is no simple answer, but central to the problem is the attitude of the medical profession to the law. If we concede that legal considerations can affect our medical practice then we are abdicating our judgement and our profession. I do not think that any doctor can practise medicine if he feels that he has a lawyer breathing down his neck.

Once we have relieved ourselves of the anxiety created by the spectre of the law we can start to think rationally about the problem of *x*-rays in accident cases. But when it comes to formulating guide lines it is found to be very difficult to lay down any hard-and-fast rules and there are many pitfalls. The following is a list of recommendations which we have drawn up for the guidance of junior hospital staff dealing with accident cases. We appreciate that these suggestions are no substitute for clinical judgement and should not prevent the exercise of discretion in particular cases. These recommendations are submitted to your readers as a basis for discussion. Criticisms would be welcomed.

Requests should not be made for *x*-rays unless the patient has been examined.

X-rays should be taken for *medical* and not legal reasons. There are no valid legal reasons for taking *x*-rays in the emergency department. As a general rule the indications for *x*-rays are when a fracture is suspected either from the nature and severity of the injury or from the evidence of the clinical examination.

Where evidence of fracture is lacking and the patient requests an *x*-ray for reassurance or where the doctor is uncertain he should give symptomatic treatment and request the patient to report in three days for review. The position should be explained to the patient and he should be reassured that no harm will come from a delay in diagnosis of a minor fracture in the limb. No fracture in a limb which is not clinically obvious will suffer from delay in diagnosis for three days.

X-rays after 5 p.m.: Efforts should be made to reduce the number of calls on the duty radiographer. If there is clinical evidence of a fracture which is a minor injury then *x*-rays can be delayed until the morning. Examples of such injuries are fractures of clavicle, nose, toes, and fingers. Discretion can be exercised in the need for emergency *x*-rays of minor fractures.

Since the harmful effects of a missed fracture of the skull may be serious from an early stage it is advised that all head injuries who are not admitted should have an *x*-ray of the skull. This is especially important in wounds involving the temporal or orbital regions of the skull. Even small wounds in these areas may have perforated the skull, and when in doubt these cases should be admitted for observation. Head injuries admitted because of concussion should, as a general rule, be *x*-rayed before admission to the ward. However, if the case is one of simple concussion and is admitted overnight the *x*-rays can be delayed until the morning.

Injuries to the chest wall: Where a patient has received a simple knock or bump to the chest wall *x*-rays of the chest should *not* be taken "to exclude rib fracture." Only when there is a possibility of intrathoracic damage should radiographs be requested—that is, when there is strong clinical evidence that rib fracture is present, or, in the absence of clinical signs of rib fracture, when there is clinical evidence of pneumothorax or haemothorax or respiratory signs and symptoms.

Multiple injuries: Where the patient is severely injured *x*-rays should be delayed until shock has been treated. Do not ask for multiple *x*-rays for fear of missing a fracture; allow time for careful examination while treatment for shock is proceeding.

Golden rules: (a) All *x*-rays of the skull should include the cervical spine; (b) All *x*-rays of fractures of the shaft of the femur should include the pelvis; (c) All wounds in the temporal and orbital regions of the skull which could have been caused by a perforating injury should have careful *x*-rays, however small the wound and even if there was no loss of consciousness.

—I am, etc.,

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Epidemic Malaise

SIR,—We would like to comment upon the article "Royal Free Epidemic 1955, a Reconsideration" (3 January, p. 7) by Drs. C. P. McEvedy and A. W. Beard, to whom access to our records was given and with whom we co-operated in organizing a study of certain factors in the past and subsequent histories of 100 nurses who were patients in our epidemic and 100 matched controls. This study was designed to determine if there was any evidence of a possible predisposition to psychoneurosis in the affected group, and we are surprised that no reference has been made to the results.

We considered a diagnosis of hysteria at the time of the outbreak and would like to emphasize a few of the facts that led us to believe the epidemic was one of organic disease. The epidemiological factors which Drs. McEvedy and Beard claim to support a diagnosis of hysteria are at least as compatible with a diagnosis of an infective illness. As compared with the male population, the female population was largely residential and the more likely therefore to be involved in an epidemic. The sparing of the patients may well be accounted for by their greater age.

A most important piece of evidence that has been ignored is that sporadic cases showing a similar clinical picture were observed in the population of North-West London before and after the Royal Free outbreak. The almost exact similarity of outbreaks reported from many parts of the world is also at least as suggestive that this is a specific organic entity as that it is hysteria.

Though the majority of laboratory tests proved negative qualitative changes in the morphology of lymphocytes in a substantial proportion of patients were observed. However, it is chiefly on clinical grounds that we base our belief that the outbreak was organic in origin.

The clinical picture included fever (89%), clear cut objective neurological signs such as