BRITISH MEDICAL JOURNAL

SATURDAY 20 JANUARY 1979

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NO 6157 BRITISH MEDICAL JOURNAL 1979 VOLUME 1 147-210
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

ASTM CODEN: BMJOAE 1 (6157) 147-210 (1979)
WEEKLY. SECOND CLASS POSTAGE PAID AT NEW YORK NY

CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Hepatitis in clinical laboratory staff

SIR,—In view of recent publicity and interest in the risks of hepatitis to laboratory staff, may I draw attention to the ongoing survey being carried out through the Association of Clinical Pathologists ?[1-4] During the first seven years, 1970-6, 81 cases were reported in laboratory staff, 34 of hepatitis B. None was fatal and in only a quarter was hospital admission recorded. Some of these infections were presumably acquired in ordinary life outside the laboratory. Indeed, seven cases (including two of hepatitis B) had histories of personal contact (household or otherwise) with jaundice outside the laboratory (six cases) or onset of illness within a month of joining the staff (or both); they comprised three technical, one medical, one scientific, and two members of other categories of staff.

The defined population studied allows calculation of attack rates, which fell from 111-143 per 100 000 person-years in 1970-4 to only 35 in the next two years, when nine were reported altogether. None of the five cases in 1976 was attributable to hepatitis B. Biochemistry technicians were the only group whose attack rate of 146 in 1975-76 remained significantly above the low overall rate; they include two of the three hepatitis B cases in this period. Morbid anatomy and microbiology technicians showed consistently low rates. No figures of similar quality are available to determine whether the general rate in laboratory staff is now appreciably higher than that in the outside population of corresponding age and socioeconomic status, but for most groups of laboratory workers the risk of hepatitis now appears encouragingly small.

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[1] Grist, N R, *Journal of Clinical Pathology*, 1975, **28**, 255.
[2] Grist, N R, *Journal of Clinical Pathology*, 1976, **29**, 480.
[3] Grist, N R, *Journal of Clinical Pathology*, 1978, **31**, 415.
[4] Grist, N R, *Medical Microbiology and Immunology*, 1978, **166**, 239.

Rugby injuries to the cervical cord

SIR,—The recent article by Drs T Gibson and J E Davies (23-30 December, p 1759) pointing out the high incidence of injuries sustained by players during games of rugby and the article by Dr J P R Williams and Professor B McKibbin (p 1747) drawing attention to the particular vulnerability of the cervical spine are of the greatest importance.

I am concerned with this matter as I am currently treating five players with catastrophic injuries to the cervical spine sustained while they were playing rugby, four of whom are schoolboys. Altogether I have experience of some 30 similar patients, the majority of whom I treated personally at the Liverpool Regional Paraplegic Centre and the National Spinal Injuries Centre, Stoke Mandeville, between 1965 and 1978. I have written previously on this matter[1 2]; but when I last reported I had seen only some 18 patients. Eight of the present number are schoolboys.

Schoolboys seem to be particularly at risk. Four of them were playing against adults; two of the schoolboys did not have games that particular afternoon and were playing with local adult teams. Although boys appear physically grown-up at 17 or 18 they have not the strength or the experience to match a full-grown man of 30 or 35, and unfortunately an adult may make up in vigour what he has lost in skill and speed. This is particularly dangerous in the front row of the scrum, where one can legally try to push one's opponent up or down to disrupt the heel. A further factor may be that the ligaments and bones are not so tough at this age and the bones are more easily injured and dislocated than later on.

The borderline between vigorous and illegal