The perilous skateboard

SIR,—I am intrigued by the conflicting attitudes of your two recent correspondents on this subject, Dr A R Rogers (15 October, p 1026) and Dr S P Glascoe (5 November, p 1222). The one berates the BBC programme "Nationwide" for encouraging skateboarding and implies that the medical profession should be campaigning against "this dangerous sport." The other maintains that injuries from this pastime are only minor and relatively infrequent, and that skateboarding is making a positive contribution to teenage recreation.

Reviewing the skateboard injuries seen in the accident and emergency department of this hospital reveals that the highest incidence was one a day during August, but it dropped to 23 in September and was only two a week in October. For a popular teenage sport overall this is not a high incidence, but what is disturbing is the large number of fractures in these patients. For all sports injuries our incidence of fractures is 14·8%, but for skateboard injuries it is 22·6% and these are mostly forearm and wrist fractures. To fall from a skateboard on to the outstretched hands at the modest speed of only 15 mph (24 kph) can result in a forearm fracture. To avoid such an injury the skateboarder should not only wear helmet and padding but also learn to roll as he falls rather than taking the whole impact on his outstretched hands.

Whatever the attitude of the medical profession should be to this sport, there seems little doubt that we shall see a temporary epidemic of skateboard injuries in the last week of the year when Father Christmas has distributed the thousands of new skateboards that are now in production.

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SIR,—I cannot let Dr S P Glascoe (5 November, p 1222) dismiss his responsibilities so easily. I have recently made my views on this new sport clear (*Daily Telegraph*, 1 November, *Express and Echo*, 26 October, "Westward Report," ITV 3 November, etc) and have been amazed at the reaction nationally and locally. These views, albeit rather overdramatically publicised by the press, are that any sport has risks and that participants should be fully aware of these when they take it up. In the case of skateboards the media and commercial interests have not, understandably in the latter case, given the information that will enable participants or their parents to make their choice between declining to indulge in sidewalk-surfing and perhaps, if they do indulge, of suffering the significant risk of injury which, in a small minority, may maim. It has been my purpose in the south-west to make public the statistics that have been freely available to doctors for some time.[1 4]

It is not necessary to promote the negative in these matters, and I have been instrumental in bringing together, for instance, the Sports Council and a group of responsible local entrepreneurs who plan a track in Exeter and in drawing the attention of a very large number of parents to the merits of investing in a properly designed fibreglass board rather than one of the supermarkets' cheap imitations that even quite advanced skaters would have difficulty in controlling and particularly in stopping. Here, Dr Glascoe, is where cars and even children's cycles differ: they have brakes!

In the south-west the producer of "Westward Report" found 100 recorded skateboard injuries during October, almost entirely among the 5-15-year age group—the surfers who take up skateboarding in the winter are more expert and wear more protective clothing than the youngsters. The experience of orthopaedic surgeons in Hawaii and Southern California clearly shows us that once skateboards catch on the sport takes off in a big way, and it might be unwise to ignore the implications for casualty and paediatric departments or to pretend that an epiphysial injury in a child has no more significance than a tap fracture at soccer or having your ear bitten by a Newport prop forward.

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[2] Atienza, F, and Sia, C, *Pediatrics*, 1976, **57**, 793.
[3] National Centre for Health, US Department of Health, Education and Welfare, 1975 statistics.
[4] National Electronic Injury Surveillance System, United States Consumer Product Safety Commission.

SIR,—Dr S P Glascoe (5 November, p 1222) says, "Skateboards are like cars: they are not dangerous, but the people who use them may be."

Like cars, they are lethal weapons and their use should be legally restricted to tracks or areas specially provided. At present as ridden in our streets they are indeed perilous—for the ordinary pedestrian.

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Primary excision of brain abscess

SIR,—Mr A R Choudhury and his colleagues (29 October, p 1119) are to be congratulated on treating 16 consecutive cases of brain abscess by primary excision with only one death. Unfortunately the data contained in their paper are quite inadequate for the didactic statement that "immediate primary excision is therefore the treatment of choice."

The long-standing controversy between the proponents of aspiration and those of excision relates only to supratentorial abscess, and the authors report only 14 patients (with one death) with such lesions. Conclusions about methods of treatment can never be drawn from such small numbers. Only two patients were examined by computerised axial tomography (EMI scan), but this method of examination has now virtually replaced other radiological methods in well-equipped neurosurgical departments. The use of sequential scans now allows much more accurate assessment of size of abscess and extent of brain oedema, and my own recent experience has been that patients can often be managed safely after initial aspiration without either repeated needling or craniotomy. Furthermore the results of recent excellent microbiological work[1 2] have contributed to this trend.

It is surprising that, having admitted that "the incidence of epilepsy cannot be accurately estimated in this series because of the limited follow-up," the authors in the same paragraph claim "a very low incidence compared with that in other series" and do not refer to the most valuable and recent paper on this topic,[3] which noted a mean interval of 3·3 years between surgery and onset of epilepsy; the incidence of epilepsy was as high after excision as after repeated aspiration.

When extremely divergent views about methods of treatment exist the truth is likely to lie somewhere between the two. It is unfortunate when one extreme view is reiterated, particularly on inadequate evidence and in conditions which are only partly relevant to current neurosurgical and neuroradiological practice.

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[2] de Louvois, J, *et al*, *British Medical Journal*, 1977, **2**, 985.
[3] Legg, N J, *et al*, *Brain*, 1973, **96**, 259.

SIR,—As Mr A R Choudhury and his colleagues state (29 October, p 1119), the mortality of brain abscess is indeed related to its space-occupying effect. The only absolute statement that follows regarding treatment is that the raised intracranial pressure should be relieved by some form of surgery while the patient is neurologically alert.[1] The choice of this surgical procedure will vary from patient to patient.

Primary complete excision where possible is widely accepted as the treatment of choice for cerebellar abscesses.[2] In the case of supratentorial abscesses it is sterile to argue in favour of one method alone because there is a place for both an aspiration drainage technique and excision of the whole abscess.[3 4] Complete excision may be the ideal, but this cannot by any means always be realised.[5] Abscesses that are multiple, massive, or deeply situated cannot be excised, completely or otherwise, without severe morbidity.

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[3] Cavey, M E, Chou, S N, and French, L A, *Journal of Neurosurgery*, 1972, **36**, 1.
[4] Jefferson, A A, and Keogh, A J, *Quarterly Journal of Medicine*, 1977, **46**, 389.
[5] Samson, D S, and Clark, K, *American Journal of Medicine*, 1973, **54**, 201.

Treating dissenters

SIR,—Dr Edward Hare (29 October, p 1136) suggests that our response to Soviet psychiatrist colleagues who serve the KGB by ruling mentally healthy dissenters insane should be one of "sympathy rather than abhorrence." We are puzzled that he should reach this conclusion after reading our book, *Russia's Political Hospitals*, as we document there in detail the reasons why these psychiatrists cannot be considered colleagues.

In chapter 8 we distinguish carefully between three groups of Soviet psychiatrists vis-à-vis the abuses: a core group of several dozen doctors who occupy powerful positions and who have undoubtedly prostituted themselves; the vast majority of average psychiatrists who try to evade the KGB efforts to involve them in unethical practices; and a minuscule group which actively opposes the abuses.

The core-group psychiatrists have for several years co-operated fully with the KGB and defended Soviet psychiatry against Western allegations. We record numerous instances of their blatant unethical conduct and deceitfulness in both spheres. Dr Hare need only read our account of a meeting held in 1973

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