

nails, pitchforks, and animals are frequent and will remain so while wellington boots are the standard footwear on farms.

The physical labour of farming causes many musculo-skeletal injuries, some with a seasonal incidence. Harvesting root vegetables produces a spate of forearm injuries. Autumn, with its heavy rains, increases the incidence of wry necks. Lateral popliteal nerve damage is a hazard for strawberry pickers. Forestry workers develop Raynaud's phenomenon from the vibration of chain saws. Hands are injured by the weather, machinery, and chemicals. Back injuries are a problem round the year. Tractors cause crush injuries, and those driving them are exposed to hazards from noise and inhaling dust from crops, fertilisers, and pesticides. Orf and ringworm are common but minor disabilities. Brucellosis still occurs in some areas and may be prostrating. Farmer's lung is common among hill farmers, and in its chronic stage this crippling disease is comparable with the pneumoconiosis of mineworkers.

Indeed, just as the miner is identified by his blue scars, so is the farmer by his ruddy complexion—and, when he lives on an upland farm, by his frost-bitten ears. Both are exposed to the hazards of occupational respiratory disease. Both are injured frequently in the course of the work. Both are at risk from a wide range of other occupational hazards. But an important difference exists. In common with many other groups, including civil servants and hospital employees, the miner has his own separate occupational health service. No such service exists for the farmworker. Admittedly such a service would be difficult to implement, but perhaps one should be established. Alternatively, the formation of a small body to study the hazards of farming would at least help to focus attention on this important industry.

¹ Lar, R, *Medical Journal of Australia*, 1977, 2, 186.

Golfers' wrist

On Monday mornings nowadays doctors see a succession of patients complaining of painful joints and muscles from their weekend exertions as more people take up amateur sports and play them with varying degrees of proficiency. The injuries are often minor and self-resolving, but some may not only prevent further participation in the sport but also interfere with work.

In many sports in which a ball is struck with a bat, club, or racket the wrist may be injured—either by overuse or by abrupt interference with the swing. In Spain, where there is a national insurance scheme for amateur and professional sportsmen, 8% of tennis injuries and 10% of golfing injuries are estimated to occur at the wrist. A careful history and examination should help to make an accurate diagnosis.¹ There are two main groups of lesions, articular and extra-articular. The most common extra-articular problem is tenosynovitis of either the flexor or the extensor tendons; damage to flexor carpi ulnaris is particularly common in golfers. Intra-articular

problems include fractures, fracture dislocations, tears of the interosseous cartilage, and sprains of the capsule and surrounding ligaments. These ligamentous injuries are not common and should not be diagnosed until other possibilities have been excluded. The early diagnosis and treatment of scaphoid fractures are well documented, as are fracture dislocations at the wrist. Another, less common, injury is the chip fracture of the triquetrum, which requires only active mobilisation.

Not so familiar, however, is an injury found almost exclusively in club-swinging sportsmen: fracture of the hook of the hamate. Since this bone is situated on the ulnar border of the hand, proximal to the pisiform, it lies immediately beneath the end of the club, which may impinge on it suddenly, breaking off the hook. The fracture has been described in those playing golf,² baseball, and tennis.³

The lesion produces pain in the ulnar border of the wrist, and there is obvious tenderness to direct pressure over the hamate or the dorso-ulnar aspect of the wrist. Plain radiographs of the wrist will not show the fracture, and several carpal tunnel views may be required to show the hook satisfactorily.⁴ The fracture may be complicated by an ulnar nerve lesion,⁵ non-union, or rupture of the flexor tendons overlying the rough edge of the hamate. The initial treatment is immobilisation, but, if non-union occurs and symptoms persist, the separated fractured hook may need to be excised. In one case in which the flexor tendons ruptured several local steroid injections had been given, and these may well have contributed to the rupture.

Patients with sports injuries often present for treatment late; their condition may then be diagnosed incorrectly or inaccurately and managed inadequately. Nevertheless, data on the incidence of injuries are difficult to obtain and controlled trials comparing treatments difficult to construct. More easily accessible sports injury facilities would make it possible to produce much-needed data and untangle the club-house mythology so often dispensed at present to injured amateur sportsmen.

¹ Cyriax, J, *Textbook of Orthopaedic Medicine*, vol 1, 6th ed, p 268. London, Baillière Tindall, 1975.

² Torisu, T, *Clinical Orthopaedics and Related Research*, 1972, 83, 91.

³ Start, H H, et al, *Journal of Bone and Joint Surgery*, 1977, 59-A, 575.

⁴ Andress, M R, and Peckar, V G, *British Journal of Radiology*, 1970, 43, 141.

⁵ Howard, F M, *Journal of Bone and Joint Surgery*, 1961, 43-A, 1197.

Spring in Gibraltar

Next year the BMA is holding its annual clinical meeting in Gibraltar (see p 1680), so providing doctors with a chance of combining an early holiday with some postgraduate education. The military traditions of the Rock will attract historians, while the options in the travel arrangements include a visit to Tangier for those wanting to set foot in Africa. BMA spring meetings have acquired a reputation as good-humoured, friendly occasions with a nice balance between medicine and tourism; this one should prove no exception.