

insufficient to enable the active treatments to be compared. Acupuncture and nicotine gum were effective in helping smokers to stop smoking during the first month but did not reduce the tendency to relapse after that time.

The subjects in our trial did not take the initiative in coming to a clinic to stop smoking but were invited to take part. This may explain our low long term rate of success compared with that of withdrawal clinics.

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Squash rackets: a survey of eye injuries in England

With the increasing popularity of the game of squash rackets over the past 15 years there has been a corresponding awareness by ophthalmologists in Western countries of the increased number of ocular injuries. In response to a need for more information on the extent of injuries to the eyes the Squash Rackets Association set up a working party, which carried out a survey of eye injuries sustained during squash from October 1982 to March 1983.

Subjects, methods, and results

Simple reporting cards were used asking ophthalmologists whose names were on the list of the Faculty of Ophthalmologists in England to report any ocular injury sustained from squash during the six month survey period and also to ask their local accident and emergency department to report similarly when appropriate, the ophthalmologist acting as collator of the reporting cards. The reporting card was deliberately brief and covered only the following aspects of the injury: date, age, sex, nature of injury, whether spectacles or eye protectors were worn, and cause of injury (racket, ball, or other).

A total of 339 players (278 men and 61 women) were reported with injuries to the eye and adnexae over the six month survey period. The youngest player was aged 7 and the oldest 61. Most of the injured players (251 out of 339) were aged 20-39.

Most injuries were caused by the ball (235 out of 339), but the racket caused 103 injuries and collision with the wall of the court caused three. Reports of injuries were received from many places in England, but those from areas of dense population and resorts on the south coast predominated.

The table shows the detailed nature of the injuries to the ocular tissues. The concussive nature of most injuries was reflected in the large number of hyphaemas (147) and retinal damage (33)—that is, haemorrhage, oedema, and detachment—whereas there were only three penetrating injuries.

Comment

Recent reports of the nature of injuries to the eyes sustained during the game of squash have come from North America, Britain, Australia, and France,^{1,4} and from these reports the squash ball was consistently recorded as the most common cause of injury. In our survey injuries caused by balls outnumbered those caused by rackets by over two to one (233 caused by balls and 103 by rackets). The severe concussion injuries that caused retinal damage and the penetrating injuries may have caused some degree of permanent visual impairment; 40 out of 339 players had such injuries.

Detailed nature of injuries to ocular tissues*

Tissue	Injury	No of injuries
Orbit	Fractures	3
Eyelids	{ Lacerations	50
	{ Bruising	40
Conjunctiva	{ Haemorrhage	18
	{ Lacerations	4
Cornea	{ Abrasions	54
	{ Perforations	2
Anterior chamber	{ Hyphaema	147
	{ Angle recession	3
Iris	{ Iritis	30
	{ Mydriasis	8
Lens	{ Dialysis	1
	{ Subluxation	2
Vitreous	{ Posterior separation	4
	{ Haemorrhage	2
Sclera	{ Perforation	1
	{ Haemorrhage/oedema	28
Retina	{ Tear	3
	{ Detachment	2

* Details of injury were unrecorded in 34 cases. Thirteen admissions to hospital were known but most were not recorded.

There are well recognised limitations in any reporting system that relies on subjects to complete card reports, and the interest and diligence of the ophthalmologists in this survey to report injuries would have varied. Family practitioners were not consulted in our survey. Despite these admitted limitations our results confirm the impression gained by ophthalmologists that injuries to the eyes during the game of squash have become more common. This first attempt to quantify these injuries does give evidence of their widespread nature, and the total number is probably greater than reported for the reasons mentioned above.

The wearing of eye protectors when playing squash has been recommended by some people and official bodies,⁵ and several eyeguards are available commercially. There is, however, no national or international standard for an eye protector. The Squash Rackets Association is examining the evidence on injuries and eye protection in the game of squash.

I thank fellow members of the Squash Rackets Association working party, Dr J G P Williams, Mr M Gilkes, and Mr J B Davey. Mr Alan Chalmers, manager of services and administration, Squash Rackets Association, provided the facilities for administering the survey. I also thank the Faculty of Ophthalmologists for support; Miss Cyrilla Chatfield, who performed all the secretarial work; and the ophthalmologists in England, who reported the cases and made this survey possible.

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Humoral antibody response after rubella vaccination

In five schoolgirls tested after vaccination under the Edinburgh rubella programme all were seronegative by single radial haemolysis, while four were positive by enzyme linked immunosorbant assay. Subsequent specimens from all five were positive by single radial haemolysis. This and other, similar results prompted us to examine vaccinees more closely, particularly with respect to the apparently slow response in antibodies detected by single radial haemolysis. Current interest in extending the British rubella programme towards the Edinburgh system¹ would involve