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Bombs and hospitals

The continuing urban violence in Britain means that doctors in all parts of the country need to know the steps to take in an incident in which many injured people arrive at one hospital without warning after an explosion.

Organising the management of mass casualties may be as important as the actual details of treatment. Both must be considered in the light of lessons from the past. Every hospital with a department large enough to receive mass casualties should have a plan, though this must be elastic because different incidents provide different problems. A rota is needed to specify which senior surgeon should be called first when casualties arrive. He should summon the required members of staff, and alert the blood bank, the x-ray department, and the senior nursing officer. An ex-directory line should be provided at a known place in the hospital so that outgoing calls can be made without trouble, while anxious relatives can ring the main switchboard. One ward and the intensive care unit should be emptied, so that all the patients can be concentrated there. This is the best way of carrying out triage—and avoiding the error, all too common in disasters in the past, by which patients have been distributed round as many as eight wards, making decisions about priorities immensely difficult.

Too many volunteers may arrive after a big disaster, some too old and others too young; and superfluous helpers may be embarrassing. A good plan is for the surgeon in charge to alert such of his consultant colleagues as he chooses and for them to summon their registrars or house surgeons, or both, whose telephone numbers they should always have with them. At an early stage someone must be stationed at the front of the hospital to discourage unnecessary helpers, anxious members of the public, and would-be blood donors. One of the administrative staff is often the most tactful person for this job. A senior doctor should be sent to the accident department to sort the patients as they arrive, into those who can have local treatment before going home, those who should be admitted but whose treatment is not urgent, and those who must be dealt with at once by either urgent operation or intensive care. These are mainly the patients with blast lung, penetrating thoracoabdominal wounds, and head injuries. The same doctor should remain in the reception area to carry out his triage function and direct the junior staff in treating the less severely injured. Large badges will be needed by everyone taking part in the action to prevent confusion. They need say only "surgeon," "doctor," "anaesthetist," "porter," or "nurse."

As soon as the first patient has been admitted, another senior surgeon should be posted to the reception ward, to establish priorities. He must stay here; for it may be necessary to rediagnose patients, to observe deterioration, and to alter the order of priorities when a more urgent case appears. He should stay where he is and not be tempted to undertake operations—continuity is all-important. It is useful to have a radiologist present to report on every case taken to the casualty department and to help the less experienced doctors. Many x-ray examinations can be deferred, and the senior doctor in the casualty department should advise about priority.

In explosions in confined areas the incidence of blast lung is greater than in the open, because the pressure waves from the explosion may be reflected from wall, ceiling, or floor. Pulmonary contusion needs urgent ventilation treatment. An early tracheostomy is often needed in management of open chest injuries and many head injuries, though it may be delayed by the passage of an endotracheal tube with a cuff.

Wounds may be contaminated or caused by flying glass, pieces of furniture, and falling masonry (besides bomb fragments), and in many of these the safest treatment is delayed primary suture. Patients with burns, unless these are very slight, should be transferred to a burns unit at once, though in severe cases it may be necessary to start intravenous treatment before the patient is moved. If there is no burns unit in the hospital or near by, part of a separate ward should be turned into a temporary unit rather than have burned patients nursed among the multiply injured in the admission ward, where they may soon become infected.

Is there a hyperkinetic syndrome?

For many years teachers and parents have followed clinicians in deciding that certain children suffer from the "hyperkinetic syndrome"—especially, it seems, in the United States, where the diagnosis is made in between 4 and 10% of all school-age children. The well-known nursery character, fidgety Phil, has to show besides his hyperactivity some other features as impulsivity, distractibility, and excitability. Since all normal children move, are impulsive, can be distracted, and become excited—and since they learn better control of themselves as time passes—boundaries have to be drawn, varying with age and maturity, between what may be regarded as normal behaviour and what is not.

The story began 40 years ago when Charles Bradley¹ observed the effect of amphetamine on a group of boys with neurological and behaviour disorders in a residential home. Half improved, notably in their school work; some became subdued; but three became agitated, noisy, defiant, and difficult to manage. Ounsted² took up the story in 1955 among 70 children with epilepsy, distractibility, fluctuation in mood, aggressive outbursts, and a short attention span, which he tried to measure. Given dexamphetamine, one-quarter improved. In 1957 Laufer and Denhoff³ reported on the "hyperkinetic behaviour syndrome" in a group of children with normal intelligence and without known neurological or other disorder. The children seemed on the move all the time. Associated with hyperactivity were difficulty in concentrating on one thing; variable and unpredictable behaviour; and low tolerance to frustration, so that reaction to delay in gratification