15-30% of patients with splenic injury.[9 10] The interval between splenic injury and delayed rupture of the organ is less than seven days in half the patients and less than two weeks in three-quarters.[11] Major injuries to the liver requiring resection of the damaged portion usually present soon after injury, but may become manifest later with evidence of an intrahepatic haematoma. Similarly major damage to the pancreas may present later with traumatic pseudocyst. In such patients in whom intra-abdominal injury is suspected selective arteriography, isotopic liver scan, or ultrasonography may greatly help in the diagnosis, though these investigations have little part to play in the initial management of patients with blunt abdominal trauma.

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Fractures near the hip

Fractures of the proximal femur are common in elderly people—whose numbers are increasing and may continue to do so until the end of this century. Clearly management of these patients and their subsequent rehabilitation are likely to present growing problems if we are to prevent our hospitals being filled with aged, immobile patients.

This fracture occurs mainly in women. Barnes *et al*[1] in their prospective study of subcapital fractures found that out of a total of 1618 fractures 1354 occurred in women of whom 40% were aged 75-84. These fractures are caused by trauma ranging in severity from very violent to as trivial as a stumble. Griffiths *et al*[2] have suggested that some patients may have sustained fatigue fractures, the fall occurring after the bone has broken. Of the two main types of fractures near the hip, those of the trochanteric region present the lesser problem. Unlike those of the femoral neck, they heal well with conservative treatment using traction and splints, though in practice most surgeons prefer to fix the fragments internally using a pin and plate.

The treatment of fractures of the femoral neck is more controversial. These fractures often fail to unite—possibly because the haematoma essential in the early stages of callus formation is washed away by the synovial fluid. The femoral head derives its blood supply from three sources: a small but variable amount via the ligamentum teres; the vessels running up the medullary cavity from the shaft; and the reflected vessels from the capsule. After a fracture, especially one with much displacement, the two main sources of blood are lost, encouraging non-union of the fracture and causing late segmental collapse of the femoral head. These problems have led many surgeons to believe that treatment based on reduction and internal fixation is doomed to failure and should be abandoned in favour of primary prosthetic replacement. Devas[3] strongly advocates this method of management in the elderly, using a Thompson prosthesis cemented in position. The incidence of complications such as infection and dislocation may be reduced by using an anterolateral approach, which allows the patient to begin mobilisation early.[3 4]

Barnes and his co-workers have shown that careful reduction and accurate internal fixation may produce excellent fracture healing and a low incidence of late segmental collapse, especially where there was little displacement. They also pointed out that the Smith-Petersen nail did not give adequate fixation, especially if there was displacement: they preferred to use either a sliding nail plate or the crossed screw method. No doubt the argument about the correct method of treatment will continue until a perfect system is devised. Until then each surgeon will do the operation he believes is correct—and as it will be the operation he performs best his patients will have little cause to worry about the academic arguments.

Total hip replacement is rarely used as a primary procedure in the management of fracture of the femoral neck. It has a role in replacing the joint in which either avascular necrosis or non-union has occurred, but only when the patient suffers pain. Those who have had the femoral head replaced by a prosthesis may also experience pain due to the metal head boring into the acetabulum; but total hip replacement is indicated only in the fitter, more active, long-term survivors.

The management of the fracture, though controversial, is generally a relatively minor problem in comparison with the management of the patient as a whole. The prognosis of this type of fracture is bad. Barnes found that 7% of women and 13% of men died within one month and Chan recorded a 14% overall mortality rate at six weeks. General problems such as diabetes mellitus, heart failure, and dehydration all have to be treated. Barnes found that one-fifth of all patients who had not been fully active before the fracture died in one month and that the death rate was much higher when the blood urea concentration was raised. Despite these hazards, most surgeons believe that all patients should have their fractures treated surgically—for if the treatment is satisfactory the patients can live out their days, however limited, in comfort.

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Is Briggs alive?

Professor Asa Briggs and his committee[1] were asked to "review the role of the nurse and the midwife in the hospital and community and the education and training required for that role, so that the best is made of available manpower to meet present needs and the needs of an integrated Health Service."

When the report appeared in 1972 it was generally welcomed, but on closer study it has since attracted wide criticism from the nursing profession at all levels. Its single most important recommendation was the creation of a central nursing and midwifery Council for Great Britain, whose primary task would be to decide what form nursing education should take—using the report as its basis. Action should not be