Comment

Running or skiing in extreme conditions was a recreational activity for these men. Natural reticence may have led to underreporting of other cases. Injury reflected a failure to appreciate the risks as well as inadequate protective clothing. Dysuria was a prominent early symptom, possibly owing to rapid rewarming of the urethra during micturition. Persistent dysuria may have been caused by damage to the urothelium from urine freezing in the distal urethra. Cold injury might be expected to have been more common among the circumcised men, but the prepuce is itself susceptible despite offering protection to the glans. Natural concern about functional impairment was expressed by all patients so the uniformly favourable outcome was reassuring. The standard initial treatment of frostbite entails rewarming

frostbitten parts in a bowl of warm water at 42°C,^{3,5} but this would clearly be impracticable in these circumstances; a shower or sauna is an alternative, but the excessive heat of a sauna is potentially detrimental. Subsequent treatment at best deals with the symptoms so prevention by loose fitting windproof trousers is the key.

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- 1 Foray J, Salon F, Foray P, *et al.* Les gelures: apports pronostiques et thérapeutiques nouveaux. À propos d'une statistique de mille cas. *Chirurgie* 1986;112:502-11.
- 2 Killian H. *Cold and frost injuries*. Berlin: Springer Verlag, 1981:43-6.
- 3 Ward M. Frostbite. *Br Med J* 1974;3:67-70.
- 4 Siple PA, Passel CF. Measurements of dry atmospheric cooling in sub-freezing temperatures. *Proceedings of the American Philosophical Society* 1945;89:177-99.
- 5 Mills WJ Jr. Summary of treatment of the cold injured patient. Frostbite. *Alaska Med* 1983;25:33-8.

Cricketing casualties and sporting siblings

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Among the injuries most commonly sustained by cricketers are head injuries in fielders, back injuries in bowlers, and facial and head injuries in batsmen.^{1,2} As England's batsmen prepare to face the awesome might of the West Indian pace attack the dangers pale into insignificance beside the hazards that befell two keen but unfortunate brothers warming up before a local Sunday league game in Middlesex last summer.

Case report

The two brothers had just begun their customary pre-match fielding practice with their team mates when brother 1 fell awkwardly twisting his right knee while running backwards to make a catch. His knee became locked in flexion and, as he was unable to take the weight on his leg, his team mates called for an ambulance. The start of the game was delayed. Meanwhile, brother 2, concerned about the quality

of his medium pace bowling, decided to spend the additional time made available in practice. Unfortunately while running up to bowl he slipped and fell to the ground, an ominous crack emanating from his left thigh. Unable to stand, he elected to accompany his brother to hospital. Clinically, brother 1 had sustained an injury of the medial meniscus, and the following day a bucket handle tear was excised arthroscopically. The x ray of the left femur of brother 2 showed a transverse fracture of the middle third of the femur (figure). He had sustained a fracture 12 years previously in a road traffic accident that had been plated. Unfortunately when it came to removing the plate two screw heads were broken off (one of these can be seen overlying the femur in the lower part of the x ray film). The two screws were therefore left in place, and it can be seen that the fracture occurred at the level of the proximal screw. After removal of these two screws he was treated by open reduction and intramedullary nailing of his fracture.

Comment

Injuries among cricketers are not uncommon. Of most concern are the head and eye injuries sustained by batsmen that occur despite the use of protective head gear.² Direct blows from a cricket ball can also produce more unusual injuries such as a splenic rupture.³ Knee injuries, particularly meniscal tears, are not uncommon among all sportsmen. Refracture of a long bone in which screws have been left is a well recognised problem as the resistance of long bones to torque stress is reduced by about half in such cases.⁴

Medical mishaps among sporting siblings are uncommon. The case of sudden death of two brothers with familial hypertrophic cardiomyopathy while playing basketball, as reported by Evans *et al.*, is perhaps unique.⁵ Although it is not uncommon to find siblings playing in the same team, it is most unusual and unfortunate for both to sustain injuries in the prematch warm up requiring urgent surgical treatment. If the difference between success and failure in sport may often be attributed to luck this report does not augur well for the resurgence of our national summer game.

- 1 Corrigan AB. Cricket injuries. *Aust Fam Physician* 1984;562:558-9.
- 2 Jones NB, Tullo AB. Severe eye injuries in cricket. *Br J Sports Med* 1986;20:178-9.
- 3 Du Toit DF, Rademan F. Splenic rupture caused by a cricket ball. A case report. *S Afr Med J* 1987;71:796.
- 4 Brooks DB, Burstein AM, Frankel VM. The biomechanics of torsional fractures. The stress concentration effect of a drill hole. *J Bone Joint Surg [Am]* 1970;52:507-14.
- 5 Evans AT, Korndorffer WE, Boor PJ. Sudden death of two brothers while playing basketball: familial hypertrophic cardiomyopathy. *Tex Med* 1980;76:48-51.

Radiograph of left femur
showing transverse fracture and
pins from previous injury