may be difficult as most women exposed to stilboestrol show some atypical features.¹⁰ Consequently, unless the colposcopist is familiar with the problems of exposure there is a tendency to overtreat these women. Caution is recommended in applying locally destructive measures for cervical intraepithelial neoplasia as up to three quarters of affected women will develop cervical stenosis.²⁷ Most women require annual colposcopy, with more frequent examination required in the presence of dysplastic change. No studies have been published concerning contraception in women exposed to stilboestrol. Lacking definite data, some physicians prefer not to prescribe hormonal contraceptives,²⁸ and as these women are already at risk of an impaired outcome of pregnancy avoiding using intrauterine contraceptive devices seems prudent.

In Britain stilboestrol was probably last prescribed in pregnancy in 1973. How relevant is this topic today? Many of those who were exposed in utero are now aged between 20 and 35. They have reached the reproductive phase of their lives and also the time when they are at most risk of cervical intraepithelial neoplasia. Whether in utero exposure to stilboestrol has any consequences for women entering the menopause and postmenopausal years is not yet known.

More generally, the stilboestrol story has important implications for clinical pharmacology and, in particular, for the use of drugs in pregnancy. It shows, if any further demonstration were needed, the absolute necessity for properly performed clinical trials—assessing both efficacy and long term side effects—before the introduction of any new treatment.

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Eye injuries in racquet sports

Proper protection needed

The causes of serious eye injury (requiring admission to hospital) have changed dramatically over the past 70 years.¹ In the 1920s occupational injuries predominated; by the 1970s road traffic accidents were becoming more important. Protective measures, including the Factories Act 1961, the Protection of Eyes Regulations 1974, seatbelt legislation, and the adoption of laminated windscreens reduced the incidence of eye injuries from these causes. Severe eye injuries from road traffic accidents are now uncommon,^{3,5} and work related eye injuries are rarely serious.⁵

The pattern of trauma continues to change. In the 1980s more participation in sport resulted in a predictable increase in the numbers of injuries. Only 0.7% of severe eye injuries were sustained at sport in 1909-13.¹ By 1967-76 the figure had risen to 4.1%,² by 1987 it was 25.1%,⁶ and by 1989, 42.2%.⁵ Sport is now indisputably the commonest cause of a serious eye injury in Britain, which seems to be rising in incidence. In addition, patients presenting with eye injuries associated with sports are more likely to have sustained sight threatening trauma than those with any other cause of injury,⁵ and almost half of those requiring admission to hospital suffer some permanent reduction in visual performance.⁶

Penetrating injury is seen only rarely in sport and is usually

associated with the inappropriate use of glass spectacles. More typical is a severe blunt injury caused by a blow from a ball, racquet, fist, or elbow. Mostly this results in intraocular haemorrhage. Many patients will have permanently damaged pupils and may later develop chronic glaucoma. The lens may be damaged, either by opacification or dislocation. Retinal breaks and detachment are sometimes seen, as are ruptures of the choroid and haemorrhagic oedema (commotio) of the macula. Any injury to the retina or choroid is potentially blinding. Blowout fractures of the floor or medial wall of the orbit are not uncommon and may result in diplopia or cosmetic problems. Fortunately, rupture of the globe from a high energy blow is rare; loss of the eye usually follows.

The immediate management of a severe blunt eye injury is conservative. An attending doctor without specialised equipment should simply exclude or confirm serious eye injury and transfer the patient to an accident and emergency department safely and quickly, with the eye padded. The patient may be shocked and may vomit, and the possibility of an associated head injury should be borne in mind. Attempting ocular examination within a few minutes of the injury is probably unwise. The eyelids should not be forced open. When possible an estimate of vision should be obtained. Using good

illumination, the pupil size, shape, and reactions should be assessed, and the presence of blood in the anterior chamber (hyphaema) should be noted. Any visual problem or any clear sign of hyphaema or other intraocular damage (including an abnormal red reflex) should result in referral to an ophthalmologist (through the accident and emergency department) on the same day.

Indoor racquet sports are an obvious target for ocular protection as they cause an appreciable proportion of eye injuries.⁵⁻⁹ Improved coaching and safer play must be encouraged, yet the often quoted claim that experience alone is adequate protection has been thoroughly disproved.⁶⁻¹⁰ Although the absolute incidence of injury is low,⁷⁻¹⁰ proper eye protectors are needed. Reports have established their effectiveness in other sports,¹¹⁻¹² but this message has yet to reach the squash and badminton courts. Very few players regularly wear ocular protection.

The American Society for Testing and Materials and the Canadian Standards Association have both produced an eye protector standard for squash, and increasingly in North America it is becoming compulsory to use those protectors. Unfortunately no British Standard for eye protectors exists for any sport. The numbers of squash and badminton players who wear protection in the United Kingdom is very small, not least because protectors are hard to find and vary widely in quality. It is highly unsatisfactory that protective spectacles for sport are sold with the kitemark for British Standard 2092 (industrial eye protector), which was never intended for sport. An appropriate standard is therefore necessary.

As emphasis on the benefits of sport increases participation

it is important that players are sufficiently well informed about the risks of injury to protect themselves. The increasing incidence of severe eye injury in sport will, we hope, be stemmed by the improved availability of adequate ocular protection. A proper standard for eye protectors in squash and badminton is now being considered by the British Standards Institution. Its formulation will take time and is only one of the steps necessary to reduce the incidence of injury. Meanwhile, we look to the organisers of the relevant sports to recognise the existence of this problem, cooperate in educating players about the possible dangers of eye injury, and coach safer play wherever possible.

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The mental illness grant

Too little, too soon

Most of the reforms of community care listed in the NHS and Community Care Act have been postponed. But some started in April this year, although these have been overshadowed by the rows over trust hospitals and fundholding general practices.

For health authorities the most relevant of these changes are the two special discretionary grants to fund new mental health services—one for drugs and alcohol projects and one for improving the social care of people with severe mental illness. Announcing the second grant, Roger Freeman, then junior minister for health, said that it was needed because social services departments have tended to give severe mental illness low priority.

With lightning speed yet considerable thought the National Schizophrenia Fellowship has already started to evaluate the use of the grant for severe mental illness. The fellowship, a voluntary organisation that represents people with schizophrenia and their carers, welcomes the grant in principle. But it fears that the money—£30m a year for three years—is inadequate. Thus the fellowship's researchers set out this spring to see how and why local authorities were applying for funding.

Time was not on the side of the researchers or the local authorities: the government announced the details of the grant last September and called for bids by the end of January. In those five months local authorities had to consult users, carers, voluntary organisations, and health workers; check their plans with district health authorities and family health

services authorities; and seek the blessing of regional health authorities before sending their bids to the Department of Health.

The fellowship had the same short period to contact local authorities and find out what those bids entailed. They wanted to know who would benefit from the grant. Would people stuck in psychiatry's "revolving door"—many of them with schizophrenia—be served any better? Were the proposed projects really new? The researchers chose a representative sample of 14 English local authorities to study in depth, covering a geographical, political, and financial spread. They then interviewed social services staff in the sample using a validated questionnaire and sought confirmatory data from the regional health authorities.

The good news is that some of the proposed projects should provide new kinds of informal help for severely mentally ill people.¹ They include self help and drop in centres, schemes to find sympathetic landlords or landladies, and befriending (which brings together mentally ill people with volunteers prepared to commit themselves to regular visits). Although there is little research to prove that such schemes affect prognosis, it is hard to deny the feeling that low key social support is a good thing in severe mental illness. It is possible, too, but not proved, that such schemes might attract people who would be put off by more formal mental health services.

But the fellowship is worried that none of the projects are aimed specifically at people with chronically disabling mental illnesses such as schizophrenia. The remit for the grant was