enforced? Why has this country smugly rejected the experience of others (which provide numerous and large, non-vandalisable litter bins) and either removed litter bins altogether or installed ludicrously small plastic ones that are overflowing or destroyed by hooligans within a few hours? And, given that much of the problem arises from sweet and cigarette wrappings and metal drink cans, should we not alter our attitudes to packaging: in the second world war we accepted chocolates and tobacco with the minimum of wrapping, and is there not a case for introducing a compulsory swingeing deposit on packaging—10p for a can or cigarette packet—thereby encouraging people to return them or to collect them for money?

Finally, there remains the rule of law, symbolically as important with litter as with any other of its provisions. Perhaps we shall realise that any government really means business when not only is the inflation rate in line with our competitors, but our drink-driving laws are enforced, football violence is a thing of the past, and our students can walk about a university campus without the fear of rape. When all this occurs it will also be doubtful whether, as happened this year, a Nordic country will be able to show a television programme illustrating the squalid conditions any traveller is likely to encounter at London Airport.

Meningococcal septicaemia

Fortunately outbreaks of meningococcal disease are uncommon in Britain and a general practitioner is unlikely to see more than one or two cases in a lifetime. Physicians specialising in infectious diseases and paediatricians are, however, aware that meningococcal disease runs a fulminating course and sometimes relentlessly progresses to death, especially in children. A recent report in the BMJ of 10 deaths in infancy from meningococcal infection highlights this rapidly fatal propensity, and the fact that many family doctors are unaware of the importance of a haemorrhagic rash in a febrile child. Meningococcal infection is a medical emergency, and there is great urgency in starting treatment with antibiotics: there appears to be a stage beyond which this has no effect on the disease, probably owing to the organism’s triggering irreversible immunological mechanisms.

Meningococcal septicaemia may start abruptly, especially in children, with fever, vomiting, and sometimes a convulsion. In babies the onset may be insidious, with apathy, anorexia, and irritability. The rash may be seen in from 20% to 50% of cases and may be macular (sometimes with lesions on the face), though typically it is haemorrhagic with petechiae or larger areas of purpura. The petechiae frequently start on the buttocks and the back, which should be examined in all children with undiagnosed febrile illnesses. Whereas meningococcal meningitis is always associated with septicaemia, the reverse does not necessarily occur, and the most fulminating meningococcal septicaemias often present without signs of meningeal irritation, in which case a purpuric rash is especially common.

The antibiotic of choice for meningococcal septicaemia is benzylpenicillin given by intramuscular or intravenous injection. Should a general practitioner suspect the diagnosis he should give the child an injection of penicillin without delay, and then arrange for immediate admission to hospital. Doctors have sometimes been concerned that giving penicillin to a child with suspected meningococcal meningitis might obscure the diagnosis subsequently, but this possibility is unlikely, as now that the cerebrospinal fluid can be examined by counter-current immunoelectrophoresis the diagnosis can be confirmed immunologically.

In the children described by Oakley and Stanton there was a mean delay of over an hour between the ambulance being called and the child reaching hospital. A practitioner suspecting meningococcaemia should consider taking the child to hospital in his own car or ensuring that the parents or relatives do so, and hospital admitting officers talking on the telephone to a general practitioner about a child with a haemorrhagic rash should advise him along these lines.

On admission to hospital the child should be given benzylpenicillin every four hours by intravenous bolus injection, reducing to six hourly when clinical response occurs; in children who are allergic to penicillin chloramphenicol is a satisfactory alternative. Intrathecal injection is unnecessary and hazardous. Intravascular coagulation is a common complication of meningococcal septicaemia but we have no evidence that routine treatment with heparin is indicated. The same advice applies to corticosteroids, although most clinicians faced with a near-moribund patient would probably give a large dose of hydrocortisone by intravenous injection.

Finally, the epidemiological aspects of meningococcal infection should not be ignored. The disease is notifiable to the medical officer for environmental health, and close family contacts of the patient should be treated prophylactically with minocycline or rifampicin. Penicillin is not effective for prophylaxis, and sulphonamides should be used only if the organism is known to be sensitive to them, as sulphonamide-resistant meningococci are now common in Britain.

Hair-raising treatment

Why, in biological terms, men become bald remains a mystery, though it may be a suitable subject for an evening’s idle discussion; but the impact of the condition on its victims is sufficient to encourage many to seek treatment for the inexorable decline in their half-million terminal scalp hairs. This is, sadly, one condition in which prophylaxis is not the best approach: of the two methods known to be effective, the careful selection of parenteral genes is impossible and early castration is unacceptably drastic.

Yet to the unbiased observer the most puzzling question is why baldness in men needs any treatment. Loss of hair is a visible sign that male hormones have been exerting their influence, so why should a man want to disguise this evidence of his masculinity? Perhaps the key lies in the fact that baldness—like going grey—normally implies advancing years, so that the search for a cure may be no more than a symptom of man’s desire for eternal youth. The NHS recognises that this desire is misplaced: it specifically excludes from its subsidised tariff the prescription of wigs for the purpose of concealing male alopecia—though should there be concomitant cicatricial alopecia or alopecia areata an NHS wig becomes available.

For the dermatologist there are two problems to be faced
whenever a patient seeks advice on this matter—apart from confirming the diagnosis. Why does the patient wish to appear other than he is, and is it prudent to suggest the various remedies that private medicine can offer? The first is a problem of body image and the second of economics and medical advice. Few, if any, dermatologists—whether in NHS or private practice—carry out hair transplantation, a technique that uses hair-bearing islands of skin from other areas of the scalp. Indeed, most physicians simply advise the patient to accept nature’s verdict—and for many male dermatologists with obvious temporal recession and even a vertical tounse of their own such advice is clearly honest. Furthermore, should an effective antiandrogen be produced its prescription would raise ethical and clinical problems, for where should the line be drawn between necessary and optional cosmetic treatment?

Perhaps because of the conservative line taken by doctors, private hair clinics have been established in many cities in Britain. Often these profess to solve problems of superfluous hair as well as hair loss. Relatively harmless but ineffective measures such as embroations and electronic massage may give reassurance. On the other hand, hair transplantation, a more dramatic treatment, may result in dissatisfied clients either because the transplanted hair fails to grow as promised or—worse still—because the areas become koiloidal. Even more disastrous sequelae can follow such extraordinary procedures, recently practised in the United States, as the implantation of synthetic hair fibres and other people’s hair. This treatment certainly produces instant hair, but infection may lead to widespread cellulitis and the formation of granulomas—leading in turn to shedding of the scalp. Doctors may be tempted to dismiss these disasters as a retribution for people impertinent enough to seek treatment from non-medical sources—but they need to be aware of the lengths (and expense) to which their patients may go. At the least, some warning about these hazards should be included when a man asks for advice on his thinning dome.

The injured liver

Four years ago, when we last had a leading article on trauma to the liver, the mortality from blunt injuries had shown a recent dramatic decline. That trend has continued, and in a report from the United States earlier this year the overall mortality in a series of 108 cases was 17%. Furthermore, only eight of the 18 deaths could be attributed to the hepatic injury. Survival is determined by the severity of injury to the liver, the presence of serious associated injuries to other organs and tissues, and delay in treatment; and it has improved with better techniques for dealing with damage to the portal vein, hepatic artery, and inferior vena cava, and gross disruption of the liver itself.

The most common causes of liver injuries are road traffic accidents and penetrating wounds resulting from gunshots. Non-penetrating injuries may be due either to deceleration, leading to splits and tears from shearing, or to direct violence, causing contusion or disruption of the liver substance. A classification of lesions into mild, moderate, or severe is important for management. Mild injuries—capsular splits and lacerations without serious haemorrhage—may be treated by suture or simple drainage and may not require blood transfusion. In moderate injuries there are deeper lacerations, tearing branches of the intrahepatic vessels and bile ducts. Adequate blood replacement should be given before ligating the bleeding vessels and repair of the liver with deep sutures, preferably of the horizontal mattress type. In severe injuries there is major disruption of the hepatic parenchyma and tearing of the hepatic veins or inferior vena cava. In the immediate control of haemorrhage packing has traditionally been regarded of little value, and compression of the portal vein and hepatic artery in the free edge of the lesser omentum by finger and thumb has proved a helpful manoeuvre. More recently haemorrhage has been controlled by the technique of selective hepatic arterial ligation. Hepatic resection or lobectomy is another recently developed life-saving technique in severe hepatic disruption: the residual liver tissue possesses remarkable regenerative capacity. Tears of the inferior vena cava can be controlled either by conventional methods such as direct suturing or side clamping or by isolation of the vessel by cross clamping below the liver and above the diaphragm. Another innovation is the treatment of major liver trauma by emergency laparotomy, with primary packing back in favour to control haemorrhage in the damaged area during immediate transfer of the patient to a specialised unit, where definitive operative treatment can be carried out.

Delay in treatment may result from difficulty in diagnosis. Here careful clinical assessment is still of paramount importance: both scanning and arteriography have proved disappointing as diagnostic aids. The physical signs may be deceptively minimal and often do not reflect the extent of intra-abdominal damage. Pattern bruising of the abdominal wall must be regarded as an indication of severe abdominal compression demanding laparotomy. Diagnostic peritoneal aspiration or lavage again may be misleading, and there should be no hesitation in proceeding with laparotomy if any suspicions are aroused.

Injuries to the liver are frequently associated with damage to the spleen, intestines, or kidneys, and there may also be intrathoracic lesions, head injuries, or fractures. These associated injuries are common causes of death from hypovolaemia due to massive haemorrhage, hypoxia from lung damage or an inadequate airway, or intracranial damage; and their presence may distract attention from the abdominal lesion, which is always more difficult to assess in an unconscious patient.

Even when damage to the liver has been recognised and repaired the patient’s problems are not over. He still has to face the possibility of respiratory failure, jaundice, sepsis, hypoglycaemia and hypoproteinaemia, a haemorrhagic diathesis, and disseminated intravascular coagulation. Severe injuries of the liver are a reminder of the multiple and important functions carried out by this organ in normal health.