One of his patients, with a 'stellate fracture overlying the superior sagittal sinus', left hospital after 2 days, recovering uneventfully. Another did not survive a sudden deterioration in hospital, despite evacuation of an extradural haematoma; he had an 'extensive temporoparietal fracture'. The third, observed then sent home without radiography, deteriorated fatally within hours; necropsy showed a 'linear parietal fracture' and subdural haematoma, the latter presumably the cause of death, although that is not stated.

As these cases illustrate, the fundamental question is the relevance of skull fractures, not their clinical signs; Mr Banerjee does not specify how management changes when a fracture is demonstrated, although I am concerned by the implication in his proposal that indications for radiography be 'more liberal at night, when vigilance . . . is difficult to maintain' that radiographs replace observation.

The only effects on the first patient - and on hospital resources - of detecting the fracture were adverse, while the second (if the treatment of the first accords with Mr Banerjee's protocol) was managed appropriately: as a neurologically intact patient he was initially observed, but treated further when he deteriorated. It is unclear that the child discharged with an undiagnosed fracture would have survived had he been admitted; Mr Banerjee's comments and the outcome in the second case are not reassuring.

If demonstrating a fracture led to, say, CT in these cases, what would have indicated surgery rather than continued observation *in neurologically normal patients*? In the enormous literature on radiography in head injury some debates are unresolved, but most workers agree (although more liberal indications may 'improve' overall statistics) that neurosurgery be reserved for patients, fracture or no, with appropriate symptoms and signs. Clinical expertise cannot be delegated to the radiology department.

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Audit of cervical cytology screening programmes

I was most interested to read the discussion paper by Ewart on the audit of cervical cytology screening programmes, (August 1991 *JRSM*, p 488) who correctly highlights the main problems as being poor organization and the near-impossibility of implementation, together with inadequate communication.

This latter aspect was certainly the case in my experience, as a former GP in Lincoln, where such a programme was implemented by the FPC (now FHSA) without adequate prior discussion with them. For example, although advised that letters would be sent out to patients on my list, by the FPC, inviting them for smear examinations, it was only some time later that I discovered these invitations were phrased in such a way that they appeared to emanate from myself!

One unfortunate aspect of the new contract for GPs is that target numbers are set before any payment results, so that in many cases time and money are expended without recompense, when these targets are not reached. So why bother in the first place? Hardly an incentive to improve the effectiveness of any screening programme.

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Treating burns by initial cooling

Gowar and Lawrence, in a letter (September 1991 *JRSM*, p 571), criticised my recommendation that prolonged initial cooling of a burn obviates the need for further management. The quoted consequences clearly indicate that initial cooling had not been suitably prolonged. They included infection.

In properly managed burns cases infection does not occur and healing is remarkable for the absence of scarring. The absence of infection probably ties in with an apparently irrelevant assertion, made by Therond[1] in 1967, that allergy encourages infection. Allergy is associated with histamine release, which also occurs in the reaction to burns when uninhabited by cooling. Histamine and shock are also associates.

Burns units have the opportunity to confirm these observations but not if I must join Therond in being dismissed outright without proper trials.

The matron at an old peoples' home opened a gas oven door, and received a fiery blast directly into her face. Her helpers brought her a basin of cold water fortified with ice into which she plunged her face with relief of pain. She kept having to come up for air with immediate return of such pain that she refused to allow an ambulance to be called, having an insight into the extent of pain during travel to Hospital. It took 3 hours for the pain to cease altogether, followed by only a few days for complete recovery. No question of plastic surgery, which, but for her successful self management, would almost certainly have been required.

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Reference

1 Therond C. Therapeutic action of a local anti-inflammatory antibiotic in the struggle against superimposed infections of infantile respiratory allergies. *La Presse Medicale* 1967;75:553-4

The cost of traffic casualties to the community

The leading article by Raffle (July 1991 *JRSM*, p 390) contains important data which ought to influence several areas of public policy, but involves two very significant omissions.

The first is the absence of any mention of the psychiatric consequences of RTAs; there is a scarcity of reliable data on these sequelae, other than the paper by Tarsh and Royston[1]. For many years, sympathetic consideration of these victims was hampered by the lack of an agreed diagnosis and by the influence of Miller's[2,3] misleading views. In recent years, though, it has been recognized that many such cases fit the rubric of post-traumatic stress disorder. The implications in relation to Dr Raffle's paper are that all data concerning victims who have suffered physical trauma from RTAs need to be substantially increased to account also for those who have sustained a psychiatric disability. It is quite likely that post-traumatic stress disorders are on the whole more prolonged than the majority of moderate physical injuries. If so, even greater increments may need to be added to the estimated toll of RTAs,