

of clinical and endocrine features in women who have polycystic ovaries.

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### Drug induced parkinsonism

SIR,—In their excellent clinical algorithm for Parkinson's disease (9 August, p 379) Dr N P Quinn and F A Husain stated that there is a lack of epidemiological evidence that patients who develop drug induced Parkinson's disease are at increased risk of subsequently developing idiopathic Parkinson's disease.

We recently followed up the 48 patients with drug induced Parkinson's disease who attended the university department of geriatric medicine in Edinburgh from 1982 to 1984<sup>1</sup> with the main intention of determining their current parkinsonian state. The main problem encountered was the high mortality among such patients (15.9% a year); hence many may have died before idiopathic Parkinson's disease could become manifest. Forty four of the original 48 patients were identified after a mean follow up period of 41 months. Of the 20 still alive, four (25%) had remission of drug induced Parkinson's disease but subsequently developed idiopathic Parkinson's disease. At 18 months of follow up this figure was 11%.<sup>1</sup> It would therefore appear that patients who develop drug induced Parkinson's disease have a reduced supply of dopaminergic neurones and that subsequent age related neuronal loss causes steadily more of them to develop idiopathic Parkinson's disease with the passage of time.

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### Guidelines for selective radiological assessment of inversion ankle injuries

SIR,—The paper by Dr M G Dunlop and colleagues (6 September, p 603), based on statistical analysis, glibly states that if x ray investigation for inversion ankle injuries were restricted to those patients with distal fibular tenderness or inability to bear weight, or aged over 60, with a further proviso of "no foot views," then in Edinburgh Royal Infirmary a saving of £15 000 a year could be made "without detriment to patient care."

I fear that this view lacks realism or an appreciation of the clinical context in which x ray investigations are requested. Most of such radiographs would be requested by senior house officers in casualty departments, who are relatively inexperienced, considering the responsibility with which they are entrusted. They need all the help they can get to be confident that they have not missed an important injury.

Considering the small radiation dose involved,

most patients expect the reassurance of radiography to confirm or exclude a possible fracture. If diagnosis were delayed because of its omission they would not be impressed that the doctor was trying to save a few pounds.

In the light of the recent reports from the Medical Protection Society and Medical Defence Union of massive increases in litigation by patients against doctors,<sup>1,2</sup> I would question whether any real saving would be made by such a restriction of radiography. The Medical Protection Society reports a case of pain in the ankle. Because of delay in diagnosis owing to failure to obtain an x ray film at an early stage £1250 was awarded for unnecessary pain and suffering. The Medical Defence Union reports a case in which £130 000 was awarded when a fracture/dislocation (of the hip) was missed when no x ray film was obtained, even though no injury had been suspected.

When patients present with a definite history of injury to the ankle it needs only a few cases in which accurate diagnosis is delayed owing to failure to perform radiography for any notional saving to be turned into a considerable loss should these patients sue.

Casualty officers at the sharp end of clinical medicine should not be discouraged from requesting any radiographs that they consider necessary after they have taken a proper history and thoroughly examined their patient. They should certainly not be constrained by any standard "guidelines."

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- 1 Medical Protection Society. *Annual report and accounts 1986 No 84*. London: MPS, 1986.
- 2 Medical Defence Union. *Annual report 1986*. London: MDU, 1986.

AUTHORS' REPLY—We are amazed that Mr Matthews thought that our statements came over as glib, as this was a carefully devised study with much prior discussion with senior accident and emergency and orthopaedic staff. It was born out of a real need for guidelines for radiography of inversion ankle injuries. Mr Matthews raises several important points. Firstly, our realism is apparent in that we believe that the current situation is unsatisfactory: there is a high rate of negative radiography and yet still patients present with fractured ankles seen at another accident and emergency department the previous day, when radiography was not thought to be indicated. Clearly, more accurate recognition of patients at high risk of a fracture is necessary. We also emphasise the importance of careful examination and deprecate scanty clinical assessment followed by the obligatory radiography, which is common practice in busy departments owing to an erroneous belief that it saves time. We believe that time and money are saved by proper examination and use of our guidelines to indicate a requirement for radiography.

The study was based on an analysis of the clinical assessment by "relatively inexperienced" senior house officers, and so the guidelines devised from it are applicable to any similar group of junior staff. Inherent in Mr Matthews's statement that casualty officers need the help of a radiograph is that the radiograph is unfailingly correctly interpreted; this is not so, with a 5.5% false negative rate and a 26.1% false positive rate in one large study.<sup>1</sup> Clearly, review by a radiologist must then be mandatory, and it therefore behoves clinicians to minimise unnecessary radiography requiring assessment by our radiology colleagues, as was pleaded by Golberg.<sup>2</sup>

It is always unfortunate when cases are cited

from defence societies' reports as it is possible to produce anecdotes of any conceivable calamity from such publications. Litigation, however, is an important aspect. At a Royal Society of Medicine symposium a conclusion was reached that a British court would not consider lack of radiography to be negligence if the patient was properly assessed.<sup>3</sup> We believe that our guidelines further emphasise the need for a proper history and examination and give three crucial parameters that should be heeded. We also emphasise that we have neither discussed nor alluded to other injuries and so Mr Matthews's comment on hip injury is irrelevant.

In summary, we think that inexperienced senior house officers will find our guidelines helpful not only to reduce unnecessary radiography but also to minimise missed fractures.

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- 1 Warren RA, Ferguson DG. Why do accident and emergency doctors request X-rays? *Arch Emerg Med* 1984;3:143-50.
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### Incarcerated inguinal hernia in infants

SIR,—Messrs P A M Raine and D G Young (13 September, p 698) draw attention to our failure to make reference to the use of rectal examination in our report on incarcerated inguinal hernia in infants (9 August, p 376). It was not mentioned because we did not think it was pertinent to the main point we wished to make—namely, that all clinicians should be aware that serious complications can develop after a simple and easy reduction of inguinal hernia in infants.

Examination of the internal ring by bidigital palpation is used at this hospital in children with confusing groin lumps to assist in the differentiation between an incarcerated inguinal hernia, hydrocoele, and inguinal adenitis and also in the occasional case in which there is uncertainty whether the hernia has been completely reduced. We do not agree with the routine use of bidigital examination, as suggested, to establish that all hernia reductions are complete. This is totally unnecessary in the vast majority of cases and would result in some small neonates having the procedure performed many times a day, each time their hernia reappears and is reduced.

The three infants in our report presented with acute abdominal pain. Bidigital examination of the internal inguinal ring was performed in all three. We disagree that the negative finding in the third case should have prevented a laparotomy being performed, as we believe that general deterioration and the development of peritonitis after reduction of a hernia needs exploration to ensure that gangrenous bowel has not been reduced.

Finally, the argument over the correct nomenclature for partial enterocoeles has been debated for centuries with numerous synonyms being used, including nipped hernia, masked hernia, lateral pinching of the intestine, Richter's hernia, and Lavater's hernia.<sup>1</sup> The first description of a Richter's hernia is credited to Fabricius Hildanus in 1598.<sup>2</sup> He described a woman with a long history of a groin hernia which unexpectedly strangulated