built between the rider and the horse and the rider and the helper have, over the years, produced some remarkable achievements and added substantially to the quality of life for people with learning difficulties.

Our 725 groups of members throughout Britain are keen to establish closer cooperation with the medical profession and would welcome visits from doctors so that they can show what they are achieving. Addresses of local groups may be obtained from our headquarters.

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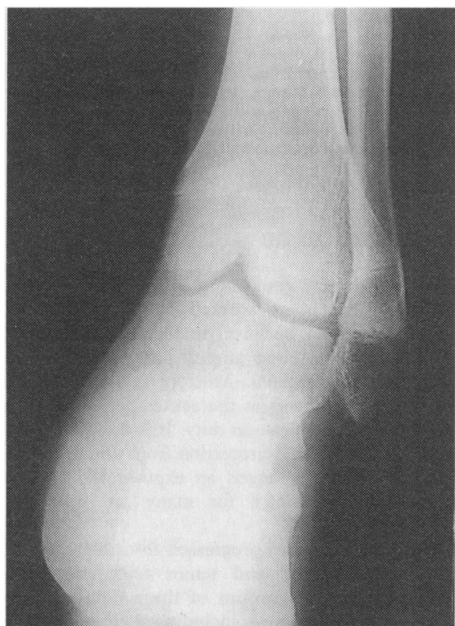
1 Chawla JC. Sport for people with disability. *BMJ* 1994;**308**: 1500-4. (4 June.)

Musculoskeletal injuries in child athletes

EDITOR,—In the article on musculoskeletal injuries in child athletes[1] little reference is made to gymnastic injuries around the elbow, which are relatively common, and no reference is made to the pulled elbow syndrome, which is also common.



Distortion of ankle joint after ankle fracture with epiphyseal injury incurred playing football

A rare but important problem also receives no mention—namely, epiphyseal damage at the time of a fracture, which may lead to subsequent distortion of the joint (figure). Epiphyseal injuries in children require regular and close follow up to monitor the development of the joint and to arrange intervention if distortion occurs.

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1 Klenerman L. ABC of sports medicine: Musculoskeletal injuries in child athletes. *BMJ* 1994;**308**:1556-9. (11 June.)

Who cares for young carers?

EDITOR,—Sue Jenkins and Candida Wingate[1] and Claire Sturge and colleagues[2] emphasise the important but neglected needs of young carers. Children's emotional needs are not met when their role in the family is distorted and they are "parentalised" by parents who, unwittingly, become dependent on them. Families change over time. Important changes occur in family roles during adolescence.[3] If a child becomes a carer this can lead to a reversal of roles and responsibilities between the parent and child.

In inner city areas doctors see many families in which the parents do not speak any English. Many professionals have to take an intimate and detailed history from a parent by using a young member of the family as a translator. This puts the child in the invidious position of being indispensable to the parents and privy to information with which, developmentally, he or she is ill equipped to deal. Children who translate for their families in their dealings with social and health care become carers for their families.

We were referred a 14 year old girl, of Turkish origin, with a two year history of juvenile arthritis. The family had lived in Britain for seven years. Her parents did not speak English. She presented because she was refusing to attend school and had panic attacks. Her father was unwell and unable to work, and the family lived on benefits. Initially her symptoms seemed related to the stress of coping with her chronic and painful arthritis. Further discussion showed that they had worsened as she took up the role of translator for the family. She expressed an enormous degree of responsibility for her family and believed without her they would be unable to cope. Her panic attacks occurred when she was confronted by authority figures and professionals: she was afraid to talk to them for fear of failing.

This case shows the parallels between caring for physically sick or disabled parents and "caring by translating" for a parent disabled because of the lack of a language. Doctors, nurses, and other professionals should make every effort to ensure that patients have access to an independent and competent interpreting service to avoid this unnecessary morbidity.

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1 Jenkins S, Wingate C. Who cares for young carers? *BMJ* 1994;**308**:733-4. (19 March.)
2 Sturge C, Frank A, Coster T. Who cares for young carers? *BMJ* 1994;**308**:1510-1. (4 June.)
3 Barnhill LH, Longo D. Fixation and regression in the family life cycle. *Family Process* 1978;**17**:469-78.
4 Barker P. *Basic family therapy.* 2nd ed. London: Collins Professional and Technical Books, 1986:162.

Increasing the number of organ donations

EDITOR,—"General practitioners are encouraged to record information about patients that is of dubious value," writes Richard Vautrey in a letter promoting the recording in patients' notes of their willingness to be organ donors.[1] Unless his patients' willingness is based on full information such records are of dubious value and could be misleading.

One hundred and fifteen of 217 respondents to his questionnaire were willing to be organ donors "when they die." This is valueless as an opinion unless what the respondents understand by the phrase "when they die" is known. How many would equate a situation in which ventilation and full resuscitative procedures continue, residual brain activity may be present but is not looked for, and paralysing and anaesthetic drugs need to be given for surgery as consistent with their having died?

This relevant information should be made available to all potential donors and their relatives and to those who are asked to sign donor cards. Every other form of consent to surgery is countersigned by the doctor who has explained the procedure and its alternatives, but this has never been required of donor cards. Without adequate explanation such consent is altruistic but not informed, and Vautrey's suggestion is of "dubious value."

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1 Vautrey R. Increasing the number of organ donations. *BMJ* 1994;**308**:1512. (4 June.)

Necrotising fasciitis

Immediate surgical opinion is essential

EDITOR,—Three aspects of necrotising fasciitis mentioned in Timothy S Burge and James D Watson's editorial require further clarification.[1] Firstly, the key to the successful management of necrotising fasciitis is the immediate referral for surgical opinion of patients with atypical cellulitis.[2] Only with early recognition of the possible diagnosis can the established guidelines of prompt resuscitation, diagnostic incision, and radical debridement be instigated, thereby improving the prospects of survival.

Secondly, the bacteriology of necrotising fasciitis is unclear because multiple organisms are usually isolated[3] and the clinical presentation does not differ according to the presence or absence of streptococci.[4] In a series of 14 patients group H streptococci were present in only three.[2] *Escherichia coli* (10 patients), *Bacteroides fragilis* (seven), and *Streptococcus faecalis* (five) were the organisms cultured most commonly.[2] The initial use of broad spectrum antibiotics, including penicillin, as an adjunct to aggressive surgery is therefore appropriate.

Finally, as the authors of the editorial are plastic surgeons I am surprised that they did not emphasise the need for early involvement of their specialty in the reconstructive phase of treatment. As many patients with necrotising fasciitis have complex associated problems, close cooperation among general surgeons, plastic surgeons, and intensive therapists is vital to achieve a successful outcome after the initial radical debridement.

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3 Pessa ME, Howard RJ. Necrotizing fasciitis. *Surg Gynecol Obstet* 1985;**161**:357-61.
4 Giuliano A, Lewis F, Hadley K, Blaisdell FW. Bacteriology of necrotizing fasciitis. *Am J Surg* 1977;**134**:52-7.

Appropriate skin flap may reduce deformity

EDITOR,—Though we support the sentiment of being "bloody, bold, and resolute" to preserve life, we question the extent of excision required in necrotising fasciitis.[1] Extensive resection of skin and subcutaneous tissues results in severe long term deformity, which is particularly disastrous when it affects the head and neck. There must be no compromise in excision of diseased tissues, including skin, but it has been widely reported that the skin is substantially less affected in necrotising fasciitis than are the subcutaneous tissues.[2]

Three of us previously suggested that, because of the basic surgical premise that healthy tissues should be respected, a large, wide based skin flap should be raised, allowing radical excision of the