

staff, whether civilians or military, should always know what they are likely to encounter when they enter a war zone or its equivalent, and should train accordingly. Secondly, they should plead for as many elements of the infrastructure as possible to be in place. Conditions may not allow the provision of this infrastructure, but when it is present it helps in the management of patients and allays the fear and despair of medical staff deployed to primitive locations.

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1 Coupland RM. Epidemiological approach to surgical management of casualties of war. *BMJ* 1994;308:1693-7. (25 June.)

## New diagnostic test for vaginal infection

EDITOR,—The rapid visual test for bacterial vaginosis developed by Thomas C O'Dowd and Nick Bourne is based on diamine oxidases and is targeted to react with diamines, cadaverine, and putrescine, which are responsible for the fishy odour associated with bacterial vaginosis.<sup>1</sup> The authors succinctly outline the steps entailed in obtaining an international patent for the test, though they have deferred publication of the relevant scientific attributes of the test. They have probably obtained extensive data on the relative utility of the test, using bacterial culture of pathogens responsible for bacterial vaginosis as the gold standard to establish a definite diagnosis in a woman. Presumably, too, they have determined the sensitivity, specificity, and positive and negative predictive values of the test and have extensively, though confidentially, subjected the test to extended peer review in the scientific community. General practitioners and office based specialists would need the above details before trusting in the utility of the test.

The test's stability at high ambient temperatures must be shown. In addition it would be desirable to investigate the test's utility in areas where ambient temperatures are below 10°C and facilities for maintaining temperatures around 20°C are not likely to be available.<sup>2</sup> If extensive clinical trials have not been done in different countries the authors may have been premature in obtaining a prompt patent: a patent does not ensure infallible performance in the field, where meritorious vaccines and prophylactic substances have performed poorly.

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1 O'Dowd TC, Bourne N. Inventing a new diagnostic test for vaginal infection. *BMJ* 1994;309:40-2. (2 July.)

2 Arya SC. Stability of human immunodeficiency virus type 1 antibodies in whole blood-impregnated filter papers under various tropical conditions. *J Clin Microbiol* 1993;31:765-6.

## Children's consent to treatment

EDITOR,—We wish to respond to the strong position taken by J P H Shield and J D Baum with respect to children's informed consent to treatment.<sup>1</sup> A doctor's responsibility to his or her patient is to diagnose and treat the patient skilfully and to disclose adequate information to enable the patient to become informed about any contemplated procedure. Only then is the patient capable of giving informed consent.<sup>2</sup>

Shield and Baum in effect propose obtaining a "combined consent," from the paediatric patient as well as the parents. Although we agree that any procedure or surgery should be discussed with a paediatric patient in terms that he or she can understand, a legal requirement to do so would not only trivialise the process of obtaining informed consent but also add a cumbersome legal manoeuvre in most cases. We agree with Gellis that "We have trouble enough as it is dealing with parents who refuse to give informed consent and that the requirement suggested by Shield and Baum "would simply [entangle doctors] in additional legal requirements."<sup>3</sup>

Belli and Carlova have reported that hospital consent forms are poorly understood by adult patients. One study showed that 61% of consent forms require a college level education for full comprehension of their contents. Unfortunately, however, only 31% of the population of the United States has any college education.<sup>4</sup>

The current law in most states of the United States has established a "bright line" for informed consent relating to paediatric patients. Parents of the patient provide their consent to the procedure being contemplated. It is relatively rare for the law to give us such clear guidance on such an important issue. Why tamper with it? We believe that eliciting written informed consent from paediatric patients is both inappropriate and impractical.

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1 Shield JPH, Baum JD. Children's consent to treatment. *BMJ* 1994;308:1182-3. (7 May.)

2 Korin JB. Legal aspects of emergency department paediatrics. In: Ludwig S, Fleisher GR. *Textbook of pediatric emergency medicine*. 3rd ed. Baltimore: Williams and Wilkins, 1993:1559.

3 Gellis SS, ed. In the UK: children's informed consent to treatment? *Pediatric Notes* 1994;18(24):1.

4 Belli M, Carlova J. *For your malpractice defense*. Oradell, NJ: Medical Economics, 1986:101.

## Case management after severe head injury

EDITOR,—We accept what seems to be the principal message of R J Greenwood and colleagues' study of the effects of case management after severe head injury—that is, that case management is not a substitute for improvement in rehabilitation services.<sup>1</sup> While recognising the need for evaluation of services, however, we believe that case management should not be disregarded as a potentially important element in a well integrated service. Our concept of case management differs from the model evaluated by Greenwood and colleagues.

The fact that the case managers in the study increased the number of contacts with the less commonly used rehabilitation services such as social work, psychology, and speech therapy is to be applauded. This, however, is only the first step in a successful rehabilitation and reintegration programme. The failure of the case managers to increase the time spent in therapy and to influence outcomes might have been due to many factors that we are not told about in the paper. For instance, the lack of an effective, cohesive, and coordinated programme of rehabilitation may have had a role. We do not know whether the different therapists communicated adequately or effectively with each

other or whether anyone made sure that the overall programmes were optimal for the patients and relatives. We do not know, for example, whether similar cognitive tests were needlessly and inappropriately repeated by a series of different professionals; whether programmes were planned and goals set together with the patients and relatives; and whether these programmes and goals were reviewed systematically. Indeed, our experience in Derby suggests that case managers work best in this role of goal setter, and measures such as "contacts with therapists" are highly suspect as sensitive indicators of good outcome. It has been more useful to look at the "appropriate" use of rehabilitation services; in some cases less rather than greater use may be appropriate.

We believe that case management will have only the limited success shown in this study unless the case manager not only is supported by an adequate and coherent rehabilitation team but, most importantly, is part of that team. The case manager should play an active part in coordinating individual patient's programmes by negotiation with the patient, relatives, and the therapists involved so that, throughout, any therapeutic input may be timely and relevant to short and long term goals that have been identified.

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1 Greenwood RJ, McMillan TM, Brooks DN, Dunn G, Brock D, Dinsdale S, et al. Effects of case management after severe head injury. *BMJ* 1994;308:1199-205. (7 May.)

## Clinical scores in the differential diagnosis of acute stroke

EDITOR,—Routine computed tomography for all patients with stroke is not available to some doctors, and this poses management problems. The Guy's Hospital score and the Siriraj score are the "poor man's computed tomography" in terms of reliability, but Maria Grazia Celani and colleagues suggest that they may be used as a temporary guide to management pending computed tomography,<sup>1</sup> and Pongvarin *et al* suggested that they could be used as a means of targeting computed tomography at cases in which uncertainty exists.<sup>2</sup> If computed tomography is not available at all (for whatever reason), or if the 10-14 days after stroke during which computed tomography can reliably differentiate infarction from haemorrhage has passed, the Guy's Hospital and Siriraj scores may still have a useful function.

If one considers, for example, the age group 75-84 (the decade in which stroke is most common) and allows for the difference in 30 day mortality between haemorrhage and infarction,<sup>3</sup> roughly 8% of the patients surviving to 30 days would be expected to have had a cerebral haemorrhage. Aspirin after ischaemic stroke can be expected to prevent 40 vascular events per 1000 patients treated for three years.<sup>4</sup> If all patients surviving to 30 days are given aspirin and it is assumed that giving aspirin to patients with haemorrhagic stroke will cause rebleeding in all cases within three years, then 80 cerebral haemorrhages will be induced per 1000 patients treated for three years. If the chance that the original stroke was haemorrhagic was 50% according to one of the scoring systems then a break even point exists. This corresponds to a Guy's score of 14 or a Siriraj score of approximately 0.5.

Our suggestion is therefore that patients surviving to 30 days who score below these values could be given aspirin while those scoring above