emergency department a short time after a relatively trivial injury. Even at this stage many of the signs described in the article are present. These include evidence of neuropathic pain, allodynia, and hyperalgesia to all stimuli. These children often undergo extensive radiology as the pain is out of all proportion to the appearance on clinical and x ray examination. Many of the children are overtreated with plaster of Paris casts or other immobilisation splints, often by inexperienced junior staff.

This syndrome has been well recognised in accident and emergency care and has been named the "10-15 syndrome."[2] I believe that, when these children present, the last thing that one should do is immobilise them in any form of splint, including tubular support bandages. These children must be encouraged to move their limbs and ideally should be referred for physiotherapy as soon as possible. Unfortunately, physiotherapy services—and particularly physiotherapists with paediatric skill—are lacking in many accident and emergency departments.

Reflex sympathetic dystrophy in children is preventable. A greater awareness of the management of soft tissue injuries in children is needed.

T F BEATTIE
Consultant in accident and emergency

Royal Hospital for Sick Children,
Edinburgh EH9 1LF

1 Lloyd-Thomas AR, Lauder G. Reflex sympathetic dystrophy in children. *BMJ* 1995;310:1648-9. (24 June.)
2 Bache J. The "10-15" syndrome. *Arch Emerg Med* 1991;2:154-5.

Child health booklets lack illustration of meningococcal rash

EDITOR,—A 14 month old child with advanced meningococcaemia died soon after admission to hospital. Medical advice had been sought when she had only four non-haemorrhagic spots, and she had remained at home for a further eight hours. Her parents, unaware of the diagnosis, watched the typical rash develop and tried to identify it by reference to a book on child health. The book contained no photographs of a meningococcal rash.

We reviewed two booklets given free to first time mothers.[1,2] Although both contained colour photographs, neither had a picture of a meningococcal rash. Such a rash was described under "meningitis," but parents would have to consider this disease a possibility before finding the description. *BabyCare Guide*, which is given to mothers in complimentary packs, does contain a colour photograph of a meningococcal rash.[3]

Some families can afford to buy glossy hardback books on child care. Nine such books published since 1990 were available in local bookstores or libraries. None had a picture of a meningococcal rash. Many listed symptoms such as fever, vomiting, and fretfulness but did not emphasise that the development of the rash alone is sufficient for parents to call their general practitioner or "trust their instincts and go straight to the nearest Accident and Emergency Department."[2]

Over half (55%) of all cases of meningococcal disease occur in children under 5, and 30% occur in infants.[4] In Europe purpuric skin lesions were associated with deaths due to meningococcaemia,[5] and their importance must be immediately clear to all. We therefore recommend that all child health books include a colour photograph of a meningococcal rash.

M WATKINSON
Consultant paediatrician

Birmingham Heartlands Hospital,
Birmingham B9 5SS

T KING

Birmingham B37 7JR

1 Health Education Authority. *New pregnancy handbook*. London: HEA, 1994.
2 Health Education Authority. *New birth to five*. London: HEA, 1994.
3 Manning M, ed. *BabyCare guide*. 30th ed. Diss: Bounty, 1995.
4 Jones DM, Kaczmarski EB. Meningococcal infections in England and Wales: 1993. *Commun Dis Rep CDR Rev* 1994;4: R97-100.
5 Olivares R, Bouyer J, Hubert B. Risk factors for death in meningococcal disease. *Pathol Biol* 1993;41:164-8.

Audit suggests that use of aspirin is rising in coronary heart disease

EDITOR,—The uptake of low dose aspirin in the secondary prevention of ischaemic heart disease has become a popular subject for audit in general practice. This was provoked by the publication of several reports and factsheets in early 1994, which showed the benefits and urged doctors to ensure that patients received the treatment.[1-3] For many practices the data are readily available and a computer search can provide the information in less than an hour.

In September 1994 six practices in Bath provided data about their patients aged 15-74 (33 293 patients in total). Three hundred and twenty five patients were known to have had a myocardial infarction, and 367 were recorded as having angina. Altogether 183 (56·3%) of the patients with myocardial infarction and 184 (50·1%) of those with angina were known to be taking low dose aspirin. A second audit eight months later showed a modest improvement to 204 (62·9%) and 260 (70·9%) patients respectively.

It has been shown that in acute heart disease women are likely to be treated later and less energetically than men.[4] The data from Bath suggested that the same may apply in secondary prevention, since a greater proportion of men than women were treated. A logistic regression model, however, showed only weak statistical evidence of there being a difference between the treatment of men and women, with a P value of 0·19 and 0·07 in the first and second audits respectively. The sample was relatively small, and a larger series might confirm a difference.[5]

RAY KING
Retired general practitioner

Bath BA2 5NL

JONATHAN DENNE
Postgraduate student

School of Mathematical Sciences,
University of Bath,
Bath BA2 7AY

1 Antiplatelet Trialists' Collaborative Group. Collaborative overview of randomised trials of antiplatelet therapy. I. Prevention of death, myocardial infarction, and stroke by prolonged antiplatelet therapy in various categories of patients. *BMJ* 1994;308:81-106.
2 British Heart Foundation. *Is secondary prevention of coronary heart disease effective?* London: BHF, 1993. (Factfile 12/93.)
3 Aspirin to prevent heart attack or stroke. *Drug Ther Bull* 1994;32:20.
4 Clarke KW, Gray D, Keating NA, Hampton JR. Do women with acute myocardial infarction receive the same treatment as men? *BMJ* 1994;309:563-6.
5 Altman DG, Bland MJ. Absence of evidence is not evidence of absence. *BMJ* 1995;311:485. (19 August.)

Water shortage in West Yorkshire has serious health implications

EDITOR,—The current widespread shortages being experienced by customers of Yorkshire Water living in the Huddersfield and Halifax areas of West Yorkshire may necessitate cuts in supply, and this has led to serious public health concerns. In view of the unprecedented nature of this problem in Britain, we believe that it is prudent to highlight the risks and problems to all doctors for their consideration now and in the future, should similar problems arise in other parts of the country.

Water supplies in the affected areas have been shrinking at an alarming rate during the summer and autumn and are currently at dangerously low levels. Although Yorkshire Water and other agencies have made repeated calls for customers to reduce demand, this has resulted in little noticeable effect on supplies.

Yorkshire Water is proposing 24 hour cuts in water supplied on a one day on, one day off basis. During the period of these cuts it would not be able to guarantee the water anywhere in the water distribution network affected, which means that all water used for drinking and to prepare food should be boiled. While hospitals would remain on a piped supply, bottled water would be necessary for use by patients and staff. Residential and nursing care homes would have tanked water supplies plumbed in. Washing and toilet management, in general, would be difficult during the cuts, and this would lead to an increased threat of community outbreaks of gastrointestinal disease. The effect on community care would potentially be severe. Patients who might have been cared for at home would be admitted to hospital, and discharges would be harder to arrange. Secondary illnesses, including myocardial infarctions, from unaccustomed activity would increase admissions to hospital, and a surge of either respiratory or gastrointestinal illness would be likely to overcome the capacity of local hospitals to cope with emergencies.

The nature of the potential problem in West Yorkshire is unprecedented. The health implications of the proposed cuts in local water supplies are extremely serious, and it is crucial that doctors working in hospitals, community health, and public health services now, and in the future, work to avoid the possibility of this situation arising again in Britain.

C WORTH
Director of public health
HOWARD BARNES
Consultant in communicable disease control

West Yorkshire Health Authority,
Huddersfield HD4 5RH

Breast cancer and hormonal supplements in postmenopausal women

Benefits probably outweigh risks

EDITOR,—Hormone replacement therapy can undoubtedly alleviate the distressing symptoms associated with the menopause, and most research indicates that, in the short term at least, it is safe. Many women feel healthier and more vivacious when taking hormone replacement therapy and wish to continue it long term, and there is evidence that prolonged treatment is associated with a reduction in mortality and morbidity from degenerative disease of the cardiovascular and skeletal systems.

We must, however, balance the benefits against possible risks. For a 50 year old woman the lifetime risk of dying of coronary heart disease may be more than five times that of dying of breast cancer, but it is the fear of breast cancer that concerns women most. We need to look at epidemiological evidence as it unfolds, and the editorial by Klim McPherson is a welcome update of the situation.[1] The latest publication from the American nurses' health study did indeed find an increased risk in the incidence of breast cancer in current long term users of hormone replacement therapy, but it also showed that among women who had used hormone replacement therapy for up to five years in the past there was a reduction in the incidence of breast