

incident procedure and the wisdom of attempting the too-hasty removal of bodies from such a scene.

**Wing Commander Ian Hill** (Institute of Pathology, RAF Halton) explained the spread of fire through the fuselage of an aircraft, and the problems posed to designers in attempting to limit passenger death in a conflagration. He pointed out that water sprinklers must reduce visibility further by the generation of steam. The particularly noxious character of the particles in smoke lead to the conclusion that smoke hoods are likely to provide the most effective and practical assistance.

**Dr D Halliday** (Metropolitan Police Forensic Science Laboratory) described the work of the specialist fire investigation unit which was established within the laboratory 10 years ago. They investigate each of the approximately 125 deaths in London each year (about 1000 occur elsewhere in the country). Dr Halliday explained the development of a fire within a building, and pointed out to the many forensic clinicians present that these are among the most dangerous of death scenes, so should not be entered without adequate protective gear.

The final speaker was **Station Officer Gardener** (London Fire Brigade) who, giving an account of the administrative structure of the London Fire Brigade since its reorganization in 1986, pointed out that the preceding 20 years had seen annual call-outs rise from 55 000 to 156 000 (this does include the rescue of cats and the release of children's heads from railings). There are now 32 female firefighters in London. Mr Gardener's own duties were complementary to those of Dr Halliday; it was no longer permissible to write a fire off as of unknown cause without examination by him and his colleagues. They did not succeed in only a very small percentage, an increasingly important safeguard when society faces a loss from arson amounting to some £300 million a year.

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## Letters to the Editor

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Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double-spaced.

### Non-specific abdominal wall pain - an expensive mystery

We welcome the attempt by Raheja *et al.* to elucidate the aetiology of so-called non-specific abdominal pain (January 1990 *JRSM*, p 10). However, in the series presented we wonder if the abdominal wall was excluded as a source for the symptoms. The preponderance of females over males (2:1), a history of previous similar episodes, the localization of pain to the right iliac fossa, and the aggravation produced on movement are all features seen in patients whose pain is parietal rather than visceral in origin. Whether or not this is the case can readily be determined by careful palpation of the abdominal wall at the site of tenderness, first with the abdominal muscles relaxed and then with them tensed. If during the latter manoeuvre the pain is increased the symptoms may be inferred to arise from the parietes since the underlying viscera are now protected from the examining hand by the tensed musculature. Thomson applied this test to 120 patients admitted as an emergency with abdominal pain and found the test positive in 24 of whom only one had a demonstrated visceral pathology<sup>1</sup>.

If the abdominal wall was excluded as a source of abdominal pain in the 80 patients described then the origin of their symptoms will continue to remain

a mystery. However, if the parietes were not exonerated then the use of bedside clinical examination would seem preferable to the time consuming and expensive tests employed in this study.

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### Reference

- 1 Thomson H, Francis DM. Abdominal wall tenderness: a useful sign in the acute abdomen. *Lancet* 1977;ii: 1053-4

### Road traffic accidents and seatbelts

I read with interest the paper by Thomas (February 1990 *JRSM*, p 79). As one who has worked at various busy A&E departments for over 24 years, I have noticed a very significant increase in the number of injuries to the anterior abdomino-thoracic region since the introduction of this legislation. Soon after this several papers were written on the subject of seatbelt related intra-abdominal injury under the title of 'Seatbelt injury syndrome', but very little has been said about injury to the anterior chest. These include crack fracture of the sternum (usually lower part) fractured ribs and costal cartilages. Costal cartilage do not show in the X-rays so the diagnosis is clinical. Radiological diagnosis of rib and sternal fractures is difficult and often missed. Another problem with thoracic wall trauma is the delayed onset of pain, which appears after 48-72 h with the onset of post-traumatic stiffness or rigidity.

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