

Eighty six per cent of cases of trisomy 13 died by 1 year, but translocation and mosaic cases may survive longer.¹ Rare reports of prolonged survival in trisomy 13^{2,3} and misdiagnosis of proximal trisomy 14 as trisomy 13⁴ exist. The increasing sophistication of cytogenetic analysis with improved techniques including FISH may detect anomalies which could earlier have gone undetected. In this case, the history of multiple miscarriages in the mother and aunt was also suggestive of a chromosomal rearrangement. Therefore, chromosome investigations should be repeated on children where the clinical picture does not fit the chromosomal diagnosis.

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Child pedestrian traffic safety – do health beliefs influence behaviour?

EDITOR,—I was delighted to read the authoritative study by Sissons Joshi *et al*¹ not simply because it lends support to the applicability of the Australian² and American³ findings with respect to cycle helmet use but also, and in particular, its promotion of the idea that presenting young people simply with the facts may not be enough. We need to ensure that

our young audience see accident prevention as applying to them in particular, and not just to the next child.

We have similarly seen this here at Tadworth as a problem for young people with respect to pedestrian safety. The majority of the referrals to our children's head injury unit come from injuries incurred as a product of pedestrian accidents. In this country we have the worst record for child pedestrian fatality in Europe for the 10-14 year age group.⁴ In an attempt to counter this a number of successful graduates from our rehabilitation programme have gone into schools to recount first hand their experiences, as a way of driving home the point that accidents happen to anyone. We have found, in our initial follow up of 134 students, that the impact in bringing home the message in this way in influencing beliefs has been very great.

The conclusion we have drawn from this programme is that young people speaking from direct experience to other young people carry far more credibility in influencing beliefs than can be accomplished simply with the presentation of a road traffic expert, doctor, or teacher. We would agree, therefore, wholeheartedly with the observation of Dr Sissons Joshi *et al* that effective health education in this area should look, not just to provide information, but rather that the presentation of that information should be done in a way that a young audience can identify directly with what is being discussed.

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'Toddler's fracture'? A recognised entity

EDITOR,—The term 'toddler's fracture' was first used in 1964 to describe an undisplaced oblique fracture of the distal tibia in children

aged 9 months-3 years.¹ Although this entity is well known to radiologists it may have escaped the attention of paediatricians.

The clinical features typically follow mild trauma, such as tripping while walking or running, or falling from a modest height. Abnormality in gait is the most common presenting feature and localised increase in temperature and tenderness over the tibia is the most consistent physical findings. Because of the mild nature of the symptoms and trivial injury, there could be unusual delay in seeking medical advice. The characteristic radiological finding is a faint oblique radiolucent line crossing the lower third of the tibial shaft. Lateral and frontal views may not detect the fractures, but internal oblique view is the most sensitive.

In the review of spiral fractures of tibia in children and their relevance in child abuse, Mellick and Reesor concluded they were more likely to be accidental than non-accidental and used the term childhood accidental spiral tibial fracture.² Tenenbein *et al* came to the conclusion that a spiral fracture of the tibia in non-accidental injury would usually occur in the upper two thirds of the tibial shaft, rather than the lower third of the tibial shaft.³

Bone in young children is highly elastic because of its high cartilaginous content. This may be an important factor in this condition. The affected leg of a child who suddenly trips while running is subject to sudden deceleration of the leg while the upper part of the body and the other leg is still in motion. This in conjunction with the compression force caused by the weight of the child, generates the shearing force to cause the fracture. The periosteum acts as a splint and prevents displacement.

Failure to diagnose toddler's fracture may lead to unnecessary child protection investigations. Occasionally the condition may be confused with osteomyelitis.

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