MATTERS ARISING

Head injury

We read with dismay the statement by Teasdale in his review of head injury that "CT should be performed if a skull fracture is present". This is supported by the un referenced statement that "The finding of a skull fracture raises the risk of intracranial injury by more than 200-fold". In a comprehensive study of the role of skull radiography in head injury by Masters et al. 71 of 21300 (0.3%) patients with normal skull radiographs had intracranial injury compared with 67 of 758 (8.8%) with skull fractures. This implies that the presence of a skull fracture raises the risk of intracranial injury by a factor of 26, but even then over 90% of those with a skull fracture after head injury will have a normal CT. To recommend that all these patients have CT will not only produce a low yield of positive results but also represents a substantial waste of resources. Additionally, in absolute terms more cases of intracranial injury occur in the group without skull fracture. Clearly, using the skull radiograph as an indication for CT is misguided.

When should CT be performed? Masters et al. reviewed 7032 patients with head injury categorised by the history and physical findings as being at low, medium, or high risk of intracranial injury. There were no cases of intracranial injury in the 5252 low risk patients, though 12 had skull fractures. All the 36 cases of intracranial injury occurred in the 1780 moderate and high risk patients, of which only 20 had skull fractures. It follows that the clinical findings and neurological state are the deciding factors in proceeding to CT. The principal indications for CT are persistent and substantial impairment of consciousness (Glasgow coma scale score of 12 or less) or focal neurological deficit. The skull radiograph should not be a consideration in this decision. Such an approach is also in accordance with the guidelines of the Royal College of Radiologists. It should be noted that these arguments relate to the indications for CT after head injury. They also relate to the indications for skull radiography after head injury, providing compelling evidence that skull radiography should be reserved for suspected penetrating injury or depressed fracture, otherwise if the clinical state merits imaging then the appropriate test is CT. However, this remains controversial and is tangential to our primary concern.

The recommendation by Teasdale that all patients with skull fracture should have CT is erroneous and is an example of the common trap of treating the radiograph and not the patient.

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Announcement from the British Neuropsychiatry Association: 1996 summer meeting

The 1996 Summer meeting will be held on 14-16 July at Robinson College, Cambridge. It will include topics on neurodevelopment, language, and the presentation of short scientific papers and single case videos by members. The Association's AGM will be held on 16 July.

For further details of these meetings please contact: Sue Garratt, Administrative Assistant, BNPA, 17 Clocktow Mews, London N1 7BB. Telephone/Fax: 0171 226 5949.

For details of membership of the BNPA, which is open to medical practitioners in psychiatry, neurology, and related clinical neurosciences, please contact: Dr Jonathan Bird, Secretary BNPA, Burden Neurological Hospital, Stoke Lane, Stapleton, Bristol, BS16 1QT. Telephone: 01179 701212 ext 2925/2929 or Sue Garratt at the address given above.