SPLINTERS & FRAGMENTS

Should drawstrings be banned from children's clothing?

Two articles address this problem but propose different approaches to resolving it. A Canadian report of two cases of fatal asphyxiation from drawstrings being caught on playground slides (*CMAJ* 1996; 155: 1417–9) highlighted the difficulties of voluntary compliance with standards and advocated several measures to alleviate the problem in a deregulatory government environment. They did not call for mandatory standards, nor did the US authors (*Archives of Pediatric and Adolescent Medicine* 1997; 151: 72–7) whose solutions depended entirely on modifying garment designs. They note that the US Consumer Product Safety Commission recommends removal of drawstrings from children's outer garments, but back away from fully supporting this position by stating that total removal is 'unnecessary or impractical' because consumers have become accustomed to them. Since there have been no deaths in the UK since drawstrings on children's clothing were banned in 1976, it seems that drawstrings are unnecessary and that eliminating them from children's clothing would be the most suitable approach.

Children and the street where they live

Most residents believe their street to be safe. It might be familiar, but it isn't necessarily safe as this Californian study of 39 injured child pedestrians showed (*Pediatrics* 1996; 98: 1096–103). Apartment dwellers had a threefold risk of injury compared with children living in single family residences. The strongest risk factor for injury was the number of cars parked in the street, presumably because visibility was reduced for children and drivers. Traffic volume was less important, perhaps because parents intuitively restrict children's exposure to busy streets. One particularly interesting finding was that children were at lower risk in streets where older pedestrians used crossings or crossed at intersections. The authors speculate that modeling of safe pedestrian behaviour might be protective for children. A high density of apartments, more than 50% of the kerbside taken up by parked cars, and heavy pedestrian traffic were much riskier street environments for children.

Bicycle helmets do work

This case-control study from Seattle's Harborview Injury Prevention and Research Center lays to rest the myth that bicycle helmets do not work in collisions with motor vehicles (*JAMA* 1996; 276: 1968–73). From a total of 3390 injured cyclists, those with head injuries were differentiated from cyclists with other injuries, all subdivided into age categories. Helmets were effective for all age groups, overall protection being of the order of 80% reduction in risk for head or brain injuries, regardless of whether the injuries were sustained in a crash with a motor vehicle or not. Helmeted cyclists would have to increase their risk taking fourfold for the argument that helmet wearing encourages greater risk taking to hold true. Nor was there evidence that they rode more cautiously.

Skiing v snowboarding

The young are quick to adapt to new forms of physical challenge, especially when they involve speed. Their enthusiasm is not always matched by their experience or aptitude, however, and they come to grief. A Californian study (*Journal of Trauma* 1996; 41: 321–5) found that snowboarders were injured far more often than skiers, and that 40% of these injuries were sustained during aerial manoeuvres. Wrist and upper limb injuries were more common among snowboarders than among skiers for whom lower limb injuries were more frequent. There was no evidence that snowboarders put skiers at increased risk of injury by their presence on the slopes—skiers were more likely to be involved in collisions than were snowboarders. A New Hampshire study of skiing injuries among children and adolescents (*Journal of Trauma* 1996; 40: 997–1001) found that speed and loss of control, particularly in the first four days of skiing in a season, were responsible for a significant proportion of injuries among the young. Ski patrols could have more influence in modifying risk taking on the slopes, along with appropriate environmental modifications.

Violence prevention v conflict resolution for adolescents

Two curriculum packages, 'Violence Prevention Curriculum for Adolescents' and 'Conflict Resolution: A Curriculum for Youth Providers', were compared for effectiveness in this US study (*Journal of Adolescent Health* 1996; 19: 111–7). Students participating in both programs reported less use of violence afterwards, but the conflict resolution package was more successful in reducing the number of injuries requiring medical treatment after fights in the previous 30 days. The conflict resolution approach, based on social cognitive theory, offered the students real-life scenarios which reinforced their skills in avoiding confrontations, and also in resolving conflicts and problem solving, while the violence prevention package simply increased their knowledge.

Community solutions to community problems

The Northland project, aimed at reducing alcohol use among young adolescents (6th to 8th grade) in Minnesota, might serve as a model for injury prevention programs. Using a sustained, multilevel approach involving parents, peers, the school and the community, with curriculum materials based on a social-behavioural model, the program demonstrated that after three years, the students exposed to the program were less likely to use alcohol and more likely to delay starting than the control group (*American Journal of Public Health* 1996; 86: 956–65).

Injury prevention knowledge of ED residents

A Los Angeles study of 390 ED residents found that although 70% believed there should be greater focus on injury prevention in their training, only 44% reported receiving lectures on the subject. Less than a third said they consistently read injury prevention literature, partly due to lack of relevant articles in the emergency medicine literature. Since emergency physicians treat an estimated 90% of injured patients who seek medical care, injury prevention should be added to postgraduate emergency medicine training (*Annals of Emergency Medicine* 1996; 28: 31–3).

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