under the impression that most Accident and Emergency Departments use this material. It somewhat alarms me to realize that perhaps this is not the case. Catgut is much more inert than it used to be and is quite safe to use for skin closure not only in scalps but also particularly in finger tip injuries, where the use of non-absorbable sutures is barbaric as removal is so painful.

My only quibble would be that chromic catgut is not necessary. Plain catgut is perfectly adequate providing proper directions are given to the patient to keep the wound dry for 5 days.

It is perhaps worthy of mention that the use of glue has now begun to supersede the use of any suture material in scalps, and in particular children are appropriate subjects for this method.

M. W. FLOWERS

Accident and Emergency Department
The General Infirmary
Leeds, England

Coroner's post-mortem reports

Sir

I recently reviewed a consecutive series of 275 coroner's post-mortem reports on patients who had passed through Lewisham Hospital's Accident & Emergency Department. The reports were compared with the clinical notes and those in which there were discrepancies between the two were scrutinized further. They were divided into four categories:

- (1) A clinically unsuspected lesion was found at post-mortem.
- (2) A clinically suspected lesion was looked for but not found.
- (3) A clinically suspected lesion was *not* looked for.
- (4) Miscellaneous discrepancies including mixtures of (2) and (3) above.

Post-mortems are performed to confirm or refute clinical diagnoses. Category (3) above should therefore not exist; yet it accounted for 21.5% of the 275 reports studied.

Sixty seven patients had died following trauma and 40.3% came into category (3). This percentage was the same for hip and non-hip trauma. None of these post-mortems had been performed by hospital pathologists.

It is particularly important if injury scoring is to be used to audit the performance of A&E departments, that we are able to obtain full and accurate post-mortem reports. It may be that the pathologists had merely omitted to mention the presence of normal findings, but this appears to be unlikely. These examinations are carried out rapidly in order to find a cause of death and are difficult for A&E staff to attend; being outwith the hospital.

It is imperative that post-mortems for multiple trauma are done properly, but I have sympathy for the overworked pathologist who only has 10 min per body. However, it seems to me that formal coroner's post-mortems on patients with isolated hip fractures are completely unproductive. In the series I looked at, these patients had been in

hospital for an average of 30.9 days. I would suggest that they, and other long-stay patients, have post-mortems done by the hospital pathologists, thus leaving more time for the coroner's pathologists to do more acute cases, including trauma. Ideally however, I would like to see multiple trauma post-mortems performed in the hospital by a pathologist with a specific interest in the subject but perhaps that is too revolutionary an idea, especially for London!

M. HOCKING

Accident and Emergency Consultant
Lewisham Hospital
London, England

Carpometacarpal dislocation: an unusual complex injury of the hand

Sir

We would like to report an uncommon case of carpometacarpal dislocation in a 30-year old man following a fall from a motorcycle at speed.

On arrival in hospital he had multiple superficial abrasions and marked swelling and tenderness over the right first and second metacarpals.

Radiographs of the right hand were interpreted as showing a spiral fracture of the fourth metacarpal shaft. This diagnosis was confirmed subsequently in the radiologist's report. No other abnormality was noted.

He was immobilized in a plaster of Paris slab and on review of this 2 weeks later the swelling was much reduced, but it was noted that the thumb appeared abnormal and there was an obvious bony lump at the base of the second metacarpal which appeared shortened. Further radiographs with oblique views (Figs. 1 and 2) showed that the first and second carpometacarpal joints were dislocated. Tomography confirmed the diagnosis. He was transferred to the Orthopaedic Department and underwent open reduction and internal fixation of the joint.

Subluxation or dislocation of a carpometacarpal joint other than of the thumb is uncommon (Ho *et al.*, 1987) because of strong ligamentous and bony stabilizers, and the diagnosis may easily be overlooked. A report of carpometacarpal dislocations by Henderson & Arafa in 1987 showed 15 of 21 patients reviewed had the diagnosis missed in the accident and emergency department and furthermore the injury was missed again in five cases when they were reviewed by the senior registrar or consultant in orthopaedic surgery.

Hazlett (1968) suggests that there are two main mechanisms of injury. The commonest is a blow to the metacarpophlangeal joint, the head of the metacarpals or the dorsum of the hand, probably with the wrist in palmar flexion. The alternative mechanism is palmar pressure exerted by motorcycle handlebars, as in this case.

Radiological diagnosis is difficult because routine radiographs may not show the displacement clearly. It has been suggested that a true lateral radiograph (Henderson &