IN RE: ABRAMS November 1992

1142 In-Plant Care of Ocular Injuries. S. L. Fox.
J. Occ. Med. 9, 358-365 (July, 1967).

The subject is discussed under the following headings: Types of injury, Eyelid, Contusion, Foreign Bodies, Chemical, Thermal Burns, and Dislocation of the Crystalline Lens. A large number of ocular injuries are of a relatively minor nature, but few can be treated adequately even in the well-equipped and properly staffed first-aid facility of most industrial plants. The most important function of the in-plant nurse or first-aid personnel, therefore, is the prompt recognition of these injuries and the proper handling of the patient until he is placed in the hands of the ophthalmologist. Not infrequently, the ultimate degree of restoration of ocular function, as well as the cosmetic end result of the treatment, will depend to a large extent on the quality and promptness of the in-plant first-aid measures which were administered. There are two major requirements: the first being a thorough recording of the history—when, where, how, and why the accident occurred. This information, as well as interpretative comments about the nature of the work the patient was doing at the moment of injury, should be relayed to the ophthalmologist. In addition, the medical record of the employee should be reviewed for prior eye injury and visual acuity determination, and this information also promptly forwarded to the ophthalmologist. The second requirement is the recording of the visual acuity, with and without correction, before the eyes or eyelids are manipulated. Many persons have no realization of defective vision in one eye until the occasion arises to test each eye separately after an injury. Medico-legally, it is of the utmost importance to have a record of visual acuity immediately prior to treatment for the protection of the first-aid personnel, as well as the physician. If it is not possible to use a vision-testing chart, one may use a newspaper or telephone book to obtain some evidence of how much vision is present. If the patient's condition precludes the recording of even this rough estimate of the visual acuity, this should be noted on the chart. The periodic recording of the visual acuity during the subsequent course of treatment serves as a valuable guide and prognostic aid. The author has seen many instances of unrecorded progress where visual acuity, immediately after the injury and before treatment, was quite good in the injured eye, and although the eye healed and visual acuity obviously improved, the patient later claimed a decrease in visual acuity for purposes of establishing a compensation claim. The minimum requirements of equipment, surgical supplies, and drugs necessary for the emergency care of eye injuries are listed. There are 10 references.

1143 Influenza in Canada. J. C. McDonald.
Can. Med. Assn. J. 97, 522-527 (September 2, 1967).

Influenza epidemics in Canada during the last 40 years are well defined in time and severity by the usual mortality statistics and by sickness-absence figures from the Labour Force Survey and the federal civil service. However, until recently, there has been little virological information to supplement these findings and much more is needed. Influenza A has probably been the most important cause of sickness and mortality, with epidemics every two or three years; influenza B has caused lesser outbreaks at about seven-year intervals and there have been no large outbreaks of influenza C. Two-thirds of the excess mortality in recent years was in persons 65 years of age and over, but the remaining one-third was distributed fairly evenly. About half the excess mortality was ascribed on the death certificate to non-respiratory causes but in perhaps half of these, death was probably hastened by less than one year. Compared to other countries, Canada has had only slightly lower mortality than the United States but very much lower—perhaps one-seventh—than Britain. There are 15 references. -- Cond. from author's summary

1144 Cardiovascular Studies on Former Endurance Athletes. K. Pyorala, et al.
Am. J. Cardiol. 20, 191-205 (August, 1967).

Sixty-one former champion endurance runners or cross country skiers, 40 to 79 years of age, w submitted to a thorough evaluation of the cardiovascular system. A control group of 54 nonathle of the same age were submitted to similar studies. Both the mean systolic and diastolic blood pressures of the athletes (137/87 mm Hg) were significantly lower than those of the controls (147/92 mm Hg). There was no difference in the serum cholesterol level or in the hemoglobin c centration of the blood between the two groups. Coronary heart disease was diagnosed in 17 of t 54 controls and in 15 of the 61 athletes. Eight control subjects, but only two athletes, had had symptoms of coronary disease. The current physical activity was greater in the athletes than ir the controls. There were fewer nonsmokers and more heavy smokers, as well as exsmokers in control group than in the group of athletes. Among men aged from 40 to 69, the electrocardiogr by Minnesota Code, showed in 5 of 49 controls and in 1 of 55 athletes Q or QS patterns indicative old myocardial infarction. Healthy athletes had a larger maximal QRS vector, a larger roentge ologic heart volume, a lower heart rate during exercise, and consequently a higher calculated maximal oxygen uptake, than the controls. -- J. Am. Med. Assn. References & Reviews

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