The Meeting was held in the Carlton Hotel, Edinburgh under the Chairmanship of Dr. G.G. Browning. To open the Meeting Dr. J.A. Moncur, Medical Officer at the Scottish School of Physical Education showed slides to illustrate the appearance of patients in a condition of shock contrasted with their appearance following adequate blood transfusion. The point was made that it was very difficult to estimate blood loss and that the degree of shock could best be assessed by an experienced surgeon.

Following this Mr. Phillip Harris, Consultant Neurosurgeon at the Western General Hospital, Edinburgh spoke on Head Injuries. The talk was profusely illustrated. There are certain special features in persons who sustain head injuries in sport which influence the pathology, management and prognosis. Thus the patient is usually young and an extradural haematoma is more likely to occur especially after the commonest injury, a simple concussion. In boxers an acute subdural haematoma is commoner. Alcohol is not a complicating factor in sports accidents. The accident is usually witnessed and vital information can be given to the doctor. The term "a good sport" is used, but a sportsman should not try to 'work off' even a minor head injury; too often dazed, amnesic players are seen wandering about the field.

All who have been concussed should be referred to hospital where they will be retained for 24 hours to ensure that complications are not arising. Shock may occur from bleeding scalp wounds. A free airway is quite essential; this is achieved by placing the patient semi-prone. The danger of vomiting and aspiration of vomitus was stressed. All persons having a head injury should be suspected of having a cervical spine injury and should be treated accordingly.

In general the prognosis is better in young persons. Help regarding prognosis, and thus regarding permission to return to the sport, is obtained by studying the post traumatic amnesia. If this is more than one hour the brain damage is severe, and the patient may take several days to recover fully.

Mr. Harris pointed out that no sport is immune from severe head injuries and illustrated a case of an angler whose gaff had penetrated the orbit and the frontal lobes of the brain after a fall. Even bird watchers could fall out of trees!

Following lunch, Mr. Maitland, Consultant Surgeon in Bridge of Earn Hospital and Member of the Mountain Rescue Committee spoke on Mountain Rescue.
Injuries and Exposure. Ten per cent of mountain accidents are immediately fatal and provide search and recovery problems which did not concern this Meeting. The others required the application of first aid under the same principles and would eventually receive the same final treatment as if they had been injured in the home or on the public highway but the site and environment of the accident would profoundly modify the application of these principles i.e. prevention of further injuries, recognition of the severity of the injuries, prevention of further shock by insulation by all means possible against heat loss and by gentle handling, speedy arrangement for proper treatment and evacuation to a safe place for further treatment. The essence of success was speed in the performance of these tasks. It was stressed that it was difficult for the inexperienced to appreciate that a Scottish mountain could change from a scene of tranquil beauty to one of menace for the untrained within the space of a few hours. In winter and early spring the conditions could vary from those in which one could sunbathe to those of Artic severity. Thus apart from the injury itself there were additional hazards related to remoteness, difficulties of terrain, state of the weather and the fitness of the party.

Details of treatment which injured climbers should receive may be found in specialised publications but stress was laid on the need to ensure the safety of the injured person by belaying him to a rock spike or other fixture and to protect him from the weather by a wind break, snow hole or tent if available. The scene of the accident must be accurately marked. There is still discussion as to whether oxygen equipment should be carried by rescue teams. There are theoretical considerations in favour of this but the equipment is heavy and would have to be provided with a hose of sufficient length to allow of the apparatus being used while being carried alongside the stretcher.

Three parties of four people had died from exposure on Scottish hills since 1946 in severe weather with blizzard conditions but this danger exists even in less severe conditions. A description of hypothermia was given with symptoms and proper treatment i.e. rest, shelter and food of high calorific value. Local heat should not be used nor should alcohol be given. There is experimental evidence that large doses of ascorbic acid could be helpful and it is arguable that tablets of this vitamin would be more valuable than glucose under the circumstances outlined.

Wide publicity should be given to measures which mitigate the effects of exposure including proper equipment, clothing and food and it was stressed that the maintenance of morale and cool judgment was essential.

Mr. Maitland concluded with a discussion of the role of the adrenal cortex in the ability of the body to cope with stress and quoted the work of Ungar (1943) reported in the Lancet.
Mr. A. McDougall, Consultant Orthopaedic Surgeon, Victoria Infirmary Glasgow, followed with a discussion of some Orthopaedic problems seen in sporting accidents. Illustrations were given of conditions which required specialist treatment to avoid long term disability with particular reference to acromioclavicular dislocation, commonly seen following falls on the shoulder, and the mallet finger which is so common in ball games. These conditions required immediate treatment and should certainly not be regarded as trivial.

Fractures of the clavicle in girls should be treated by recumbency to avoid overlap and subsequent deformity. This was well known but it was less well recognised that profuse callus formation in men could lead to disability by causing pressure on the brachial plexus. The case of a fighter pilot was quoted whose arm became numb when pulling out of a dive. The fault was remedied by removing the overgrowth of bone from the site of an old clavicular fracture.

Groin strains were often a problem. These were frequently found to be cases of myositis ossificans and were often caused by too early a return to activity. Rupture of the tendo calcaneus was often missed. This condition should always be borne in mind and looked for following injury to the heel or calf.

Mr. McDougall was in favour of returning the patient to the skillful trainer for rehabilitation at the earliest opportunity.

Further Orthopaedic conditions were discussed by Mr. Rae Simpson, Consultant Orthopaedic Surgeon at the Kilmarnock Infirmary. The minor muscle tear was very common in the athlete and had been subjected to widely varying methods of treatment. Mr. Simpson was in favour in most of these cases of a speedy return to activity and was not in favour of prolonged immobilisation. The judicious use of Hydrocortisone infiltration had greatly improved the outlook in many of these cases.

The restitution of bulk and control of the quadriceps muscle in knee injuries could not be overstressed and it was imperative that full extension of the joint should be attained at the earliest possible moment. The physiotherapist should accompany the surgeon when seeing patients so that precise instructions could be given. This was much more satisfactory than the usual route of communication through treatment cards.

The speakers were thanked by Dr. Forrester-Brown, a founder member of the British Association of Sport and Medicine who is now Vice-Chairman of the Scottish Association.