who often have impaired renal function due to the reduction in glomerular filtration with ageing will often result in life-threatening hyperkalaemia. Spironolactone is a synthetic steroid resembling aldosterone and is its competitive antagonist. It is most effective in conditions producing high aldosterone levels, for example, hepatic cirrhosis, nephrotic syndrome and Conn's syndrome. Heart failure does produce secondary hyperaldosteronism but there is no evidence of this in the patients Dr Jolobe describes, as the 24-hour urine aldosterone level is within the normal range and indeed if they were receiving ACE-inhibitors this would reduce the aldosterone level, thereby limiting the effects of spironolactone. Spironolactone will, however, inhibit the exchange of sodium for potassium ions in the distal part of the distal tube which is under the control of aldosterone and therefore cause potassium retention. The amount of potassium retained depends upon renal function. It may be better to give potassium in a controlled way in the form of oral supplements if patients who are on loop diuretics and ACE-inhibitors remain severely hypokalaemic (<3.0 mmol/l). These patients require close monitoring of their electrolytes (at least three times per week) and usually require in-patient treatment until their condition is stabilised. However, such patients constitute a small minority and this is confirmed by Dr Jolobe's three cases in 12 years. In the vast majority of patients (and particularly the elderly) with heart failure who are taking loop diuretics and ACE-inhibitors, therefore, the addition of spironolactone would probably result in hyperkalaemia. I believe this 'conventional view' is worthy of 'emphatic re-statement'.

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Psychiatry in trauma care

Sir,

The burden of morbidity and mortality following trauma cannot be overemphasized. Adedeji and Driscoll's recommendations towards setting up a trauma care service with multidisciplinary input¹ are notable, as prompt, appropriate and effective intervention has been shown to reduce this morbidity and mortality to a minimum. The suggested multispecialty trauma team from the surgical, accident and emergency, orthopaedic and anaesthetic departments is a vital step towards achieving optimum trauma care. I wish to add, however, that survivors of trauma often also suffer psychological (or even psychiatric) sequelae.

Mental health problems have been found after all levels of trauma severity and different kinds of problems may present at various stages of recovery. While some disorders appear to be the direct result of organic damage such as head injury, which can lead to long-term psychiatric problems² like seizures, intellectual impairment, personality change, psychotic illness, mood and anxiety disorders, others clearly are not. In the non-head-injured, psychiatric symptoms and disorders are also recognised and may be frequent.³ An awareness of the personal and social consequences of the injury such as threat to life, loss of mobility, loss of income, disfigurement, prospects of a lengthy hospital stay and even bereavement may precipitate anxiety and depression following trauma. Acute stress reactions can cause severe

Diagnostic criteria for post-traumatic stress disorder⁷

A The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
Response involved intense fear, helplessness, or horror

B The traumatic experience is persistently re-experienced in one or more of the following ways:

- recurrent and intrusive distressing recollections
- recurrent and distressing dreams
- acting or feeling as if the event were recurring (flashbacks)
- intense psychological distress at exposure
- physiological reactivity on exposure

C Persistent avoidance of stimuli associated with the trauma and numbing of responsiveness:

- efforts to avoid thoughts, feelings or conversations
- efforts to avoid activities, places or people
- inability to recall an important aspect of the trauma
- feelings of detachment or estrangement
- restricted range of affect
- sense of foreshortened future

D Persistent symptoms of increased arousal:

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- exaggerated startle response

E Duration of disturbance (symptoms in B, C, and D) more than one month.

F The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning

distress to the patient, pre-hospital, during admission and post-discharge. Unresolved, this may progress to the development of a post-traumatic stress disorder (PTSD) with flashbacks, horrific and intrusive memories, nightmares, avoidance of reminders of the incident and increased arousal. Diagnostic criteria for PTSD are listed in the box.

While PTSD occurred in 10% of road traffic accident victims in an Oxford study,³ other researchers in Australia reported unrecognised PTSD in 33% of the traffic accident victims in a trauma unit following psychiatric evaluation.⁴ Furthermore, within a week of trauma, 60% of assault victims at an accident and emergency department reported significant psychological distress.⁵ Distress post-injury has been documented as being highly predictive of psychiatric morbidity and development of PTSD, however, no correlation between trauma severity (measured by the injury severity score) and onset of symptoms was detected.⁶

Incorporating the psychiatrist in holistic trauma management would greatly reduce severely disabling psychological and psychiatric sequelae of trauma and enhance patient care. Although the liaison psychiatrist may not be required to start the match with the trauma team, he certainly deserves a place on the reserve bench where he can be called upon to play in the true sense of multidisciplinary trauma care.

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Coital trauma

Sir,

In his review of coital emergencies, Banerjee omitted an account of the injuries to the female genital tract.¹ Coital trauma in females is well documented.^{2–4} Such injuries were thought to be more likely in young virginal girls during first sexual intercourse, and also in post-menopausal women.³ Findings of recent studies, however, have shown a preponderance of such cases in women of reproductive age.^{2,4} Milder injuries result in superficial tears and lacerations of the vulva, vagina and vault. However, more extensive injuries can lead to involvement of pelvic soft tissue, urethra, bladder, ureter and rectum. Cases usually present with vaginal bleeding. An occasional case presenting as acute lower abdominal pain due to pelvic haematoma has been reported.⁵ Tormenting haemorrhage from a torn blood vessel leading to shock and needing urgent resuscitation and blood transfusion has also been described.²

Superficial laceration or a closed haematoma respond successfully to conservative treatment with vaginal packing. However, the majority of cases need an examination under anaesthesia for assessment of the extent of injury and its surgical repair.^{2,3}

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