LETTERS TO THE EDITOR.

THE END OF NO-DECOMPRESSION DIVING

Telita Cruises
PO. Box 303, Alotau
Papua New Guinea
April 20th 1992

The Editor,

I was of course delighted to see my letter and article published in the January-March issue. But, alas, the gremlins struck. The title of my article was "The end of NO-decompression diving". You omitted the NO from both the piece and the index. I would be grateful for a correction since the title as printed makes no sense. and I hate to give fuel to those who think I am crazy.

Bob Halstead

The Journal apologises for the mistake made in reprinting Mr Halstead's article. A corredtion will be made to the index which is in preparation.

ASTHMA AND DIVING

Diving Medicine and Assessment Centre
4 Dodson Ave
Milford, Auckland 10
NEW ZEALAND
11 March 1992

The Editor,

The debate as to whether asthmatics should scuba dive has, with some justification, persisted in diving medical publications. The known, theoretical risk of air embolus, in addition to the increased risk of provoking an asthma attack, continue to give diving physicians difficulty explaining to, and declining, enthusiastic dive candidates.

The SPUMS Journal published the New Zealand diving-related fatalities 1983-84[1], compiled by Douglas Walker, which had been previously presented to a pre-SPUMS meeting at Tutukaka by Surgeon Commander Peter Robinson. On reviewing the 20 case studies of diving deaths, 10 had medical contra-indications to scuba diving and 5 (25%) were known asthmatics. Even accepting these figures of 10 scuba diving deaths per year, (other observers recorded 12 diving deaths per year over this period of time), there were far too many diving deaths in patients who had medical contra-indications. These deaths were a major factor stimulating the formation of the New Zealand Chapter of SPUMS, the holding of conferences on diving medicine in New Zealand, and the publicity of risks of diving, with emphasis on the medical contra-indications.

Returning to the question of asthma, a 25% incidence in diving deaths is much higher than one would expect from a cross-section of the New Zealand population, in which respiratory physicians estimate under 5% have significant asthma, and 15% have reactive airways.

There appears to be much conflicting literature on asthma in diving medical journals. The numbers of diving deaths recorded here of 10 per year in a population of 3 million, is very significant. Subsequent figures have demonstrated a drop in the number deaths of persons with medical contra-indications to diving.

Allan F.N.Sutherland

Reference

1 Walker DG. Provisional report on New Zealand diving-related fatalities 1983-1984. *SPUMS J* 1986; 16 (2): 43-54

RADIOLOGY AND DIVING

Health & Safety Executive
Field Operations Division
Fraser Place, Aberdeen AB9 1UB
United Kingdom
12 March 1992

The Editor,

As part of the on-going revision and updating of its guidance on statutory medical examinations and with the over-riding wish to minimise radiation exposure, Health & Safety (HSE) has reconsidered the need for long bone radiographs of commercial divers.

The primary reasons for radiography of the hips, knees and shoulders in divers have been the detection of existing bone lesions at the commencement of diving and the early detection of osteonecrotic lesions during a diver's career. It has been acknowledged that such surveillance is particularly appropriate in certain categories of diving.

Various factors have influenced us in the decision to change the guidance. These include:

1 As mentioned above a wish to reduce the overall radiation exposure of divers.
2 A wish to shift the emphasis of the medical examination from screening towards surveillance in relation