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LEADING ARTICLES

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MEDICAL PRACTICE

NEWS AND NOTES

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Management of gastrointestinal bleeding

SIR,—We read with interest your leading article on the management of gastrointestinal bleeding (15 August, p 456). We believe that in most centres the mortality associated with gastrointestinal bleeding has not altered in four decades.[1] Therefore we were disappointed that more emphasis was not placed on the value of an integrated unit for the management of this syndrome. Hunt and others[2] showed that provision of a "gastrointestinal bleeding unit" significantly reduced mortality. We have recently adopted a policy of admitting all such patients to a designated area of our gastroenterology unit. These patients remain in the unit only during the 48 hours after resuscitation, or if an operation is needed or rebleeding occurs. Only patients with oesophageal varices are admitted to the intensive therapy unit for monitoring.

Patients in the unit are under the joint care of a consultant physician and surgeon experienced in endoscopy involving two teams on a regular rota of duty. For training purposes the senior medical and surgical residents on duty are also involved in the joint management of each patient admitted to the unit. Such a policy has been possible only because of the good will of all members of the consultant staff of this hospital. Since we adopted this policy there have been only two deaths in 84 consecutive patients with bleeding peptic ulcer disease. Furthermore, centralisation has allowed us to undertake prospective studies on the value of medical and surgical therapy in such patients.

We hope that more centres will adopt the concept of a gastrointestinal bleeding unit; it might prove more worth while than coronary care units as a means of reducing hospital deaths.

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[1] Dykes PW, Keighley MRB. *Gastrointestinal haemorrhage*. Bristol: Wright PSG, 1981.
[2] Hunt PS, Hansky J, Korman MG. *Br Med J* 1979;i: 1238-40.

Colorectal surgery—the Cinderella specialty

SIR,—I was surprised when reading your leading article "Colorectal surgery—the Cinderella specialty" (18 July, p 169) to note your assertion that the high anastomotic dehiscence rate quoted must have been "surgeon related." Aitkenhead *et al*[1] noted that the incidence of anastomotic dehiscence occurred in 7·4% of anastomoses performed under spinal nerve block, compared with 23·1% in a control group.

The advantage of regional anaesthesia for this type of procedure is that it obviates the need for the use of an anticholinesterase drug for the reversal of muscle relaxation. The anticholinesterase will, of course, cause violent peristaltic movement across the anastomotic site. Moreover, the use of regional block reduces the postoperative narcotic requirement; and it was noted in the same paper that in patients receiving morphine anastomotic dehiscence occurred after 15·2% of operations, compared with 5·9% in patients receiving pethidine.

While sharing your concern at the high incidence of anastomotic breakdown, I feel that factors other than surgical technique must be looked at.

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[1] Aitkenhead AR, Wishart HY, Peebles Brown DA. *Br J Anaesth* 1978;**50**:177.