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SATURDAY 20 AUGUST 1983

LEADING ARTICLES

- The pursuit of quality in anaesthesia** M D VICKERS ... 509
Changing patterns of cervical cancer rates
G J DRAPER, G A COOK 510
Sleeping and dreaming MICHAEL SHEPHERD 512

- "I have been back from holiday for a week and
still have diarrhoea"** ALASDAIR M GEDDES 513
Regular Review: Coronary bypasses
M C PETCH 514

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

- Serum selenium concentration related to myocardial infarction and fatty acid content of serum lipids**
TATU A MIETTINEN, GEORG ALFTHAN, JUSSI K HUTTUNEN, JARMO PIKKARAINEN, VESA NAUKKARINEN, SEPPO MATTILA, TORGER KUMLIN 517
Usefulness of apheresis to extract microfilarias in management of loiasis
LUDO MUYLLE, HENRI Taelman, ROBERT MOLDENHAUER, ROGER VAN BRABANT, MARC E PEETERMANS 519
Parathyroid hormone and 25-hydroxyvitamin D concentrations in sick and normal elderly people
M M PETERSEN, R S BRIGGS, M A ASHBY, R I REID, M R HALL, P J WOOD, B E CLAYTON 521
Systemic lupus erythematosus in Staphylococcus aureus hyperimmunoglobulinaemia E syndrome
K SCHOPFER, A FELDGES, K BAERLOCHER, R F PARISOT, J A WILHELM, L MATTER 524
Abnormal cervical smears: are we in for an epidemic? MARGARET R WOLFENDALE, SIAN KING, MARTIN McD USHERWOOD 526
Study of possible risk factors for severe retinopathy in non-insulin dependent diabetes
ANTHONY H BARNETT, JOHN R BRITTON, BRIAN A LEATHERDALE 529
Pneumococcal bacteraemia in mother and son P A FENTON, R C SPENCER, J S SAVILL, S GROVER 529
Relative palatability of liquid enteral feeds for general hospital patients: simple method of assessment
P LINDA AUTY, MARILYN A STANDING, C HUMPHREY 530
Allergy to purified bovine, porcine, and human insulins PHILIP G WILES, ROLAND GUY, SYLVIA M WATKINS, W G REEVES 531
Cardiac arrest after crush injury CHARLES ALLISTER 531
Side effects of thyrotrophin releasing hormone LARS ØYSTEIN DOLVA, FRIDTJOF RIDDERVOLD, RANGVALD KONOW THORSEN 532
Ultrasound in the screening of patients with cirrhosis with large varices
MARIO COTTONE, ELIO SCIARRINO, MARIA PIA MARCENÒ, ALBERTO MARINGHINI, GENNARO D'AMICO, MARIO TRAINA, MARIANO AMUSO,
LUIGI PAGLIARO 533
Maternal smoking and anencephaly JEAN GOLDING, N R BUTLER 533
Serum IgA concentration and hepatotoxicity in rheumatoid arthritis treated with azathioprine C HARVEY, J S DIXON, H A BIRD 534
Practice Research: Teaching practices revisited PAUL FREELING, PETER FITTON 535
Image of General Practice: Equality of experts ANN CARTWRIGHT 538

MEDICAL PRACTICE

- Personal Paper: Medicine without signs** GEOFFREY LLOYD 539
Aviation Medicine: A valediction F JOHN MILLS, RICHARD M HARDING 543
ABC of Computing: Computers in the medical library F MACGILLIVRAY, A J ASBURY 544
Learning Medicine: Interviews and offers PETER RICHARDS 548
Lesson of the Week: Brucellar spondylitis presenting as right hypochondrial pain R W MARSHALL, A J HALL 550
USSR Letter: Commissions for complaints MICHAEL RYAN 551
Any Questions? 549, 552
Medicine and Books 553
Medicine and the Media—Contribution from TERRY HAMBLIN 549
Personal View R N VILLAR 557

CORRESPONDENCE—List of Contents 558

OBITUARY 564

NEWS AND NOTES

- Medicolegal** 565
Medical News 566

- BMA Notices** 566
**Correction: From the JCC: Hospital medical
staffing structure** 565

CORRESPONDENCE

Failure of endoscopy to reduce complication rate in peptic ulcer disease K D Bardhan, MRCP.....	558	British Diabetic Association: new criteria and classification for diabetes mellitus H Keen, MD, and others.....	560	Is there another consultant lifestyle? D J Houghton, FRCS.....	562
A lottery for life J Tudor Hart, FRCP.....	558	Neuroleptic malignant syndrome J G Goekoop, MD, and H Dik, MD; P Ritchie, FFARCS; P D White, MRCP.....	560	Unit medical representatives J F Pearson, MD.....	562
Weever fish sting P Cuff, MB; C Lockie, MRCP; J R B Dixey, FRCP; Julia K Moore, MB; D O Gibbons, FRCP.....	559	BMA and nuclear war D S Josephs, MFCM, and others.....	561	Points Drug firms to blame for overlavish entertaining (L Gerlis); Carob bars (M Hanssen); Rectal administration of metronidazole (I F Lane); Antithrombotic treatment (S J Rose); Acupuncture needles as a cause of bacterial endocarditis (Jane M Benn); Which is more dangerous—cycling or flying? (D Hirst); Out of hours dispensing (J Haworth); Health hazards in the Thames (Sheena A Waitkins).....	563
Cardowan coal mine explosion R E M Archibald, FFOM.....	559	The medical effects of nuclear war J M Smith.....	562		
An Institute of Health Sir James Watt, MD.....	560	Circadian variation of lymphocyte subpopulations H L Bhakri, MRCP, and others.....	562		

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 should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

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.

Failure of endoscopy to reduce complication rate in peptic ulcer disease

SIR,—Dr G Holdstock and Dr S Colley (6 August, p 393) are to be congratulated for showing so clearly that the increased availability of endoscopy alone will not reduce ulcer complications.

I suspect that this could have been foreseen for several reasons. Firstly, for every patient with proved ulcer disease there are others in whom the diagnosis has not been made. This is partly because of a relative lack of diagnostic facilities and partly because the symptoms may not be troublesome enough to warrant referral for radiological or endoscopic examination (or sometimes the patient may have refused to have the investigations). Thus increased availability of diagnostic services in areas previously underserved may result in increased detection of ulcer disease; but even good diagnostic services are unlikely to pick up many patients with minor symptoms. Yet complications can and do occur in patients with and without appreciable symptoms, and this is not necessarily related to the severity and duration of previous symptoms.

Dr Holdstock and Dr Colley suggest that earlier treatment of those with known ulcer disease when their symptoms recur might reduce complications, but this may not happen. During a relapse complications can occur either without warning—that is, it is the first indication that the ulcer has recurred—or early, after mild symptoms for a few days, or later on, after pain has been established for several days. Patients who are asymptomatic will not have any reason to seek help before the complications occur, even if ulcer disease has been diagnosed in the past; and those with mild symptoms may not wish to do so, unless of course they have had complications previously and are apprehensive of even minor symptoms. It is, therefore, only patients with

established symptoms who may seek help earlier and in whom antiulcer treatment may forestall complications. Indeed, Dr Holdstock and Dr Colley have shown that only about one third of patients have symptoms at the time of admission with complications and less than one tenth had attended their family doctor with ulcer problems in the four weeks before admission.

Finally, though about one third of patients with ulcers develop complications at some stage, within individual relapses the chances of complications are small and unpredictable. To reduce this still further would necessitate substantially reducing recurrence of ulcers, either by surgery or by maintenance treatment with cimetidine or ranitidine (although it remains to be proved whether drug treatment will reduce the complications of ulcers, as opposed to the recurrence alone). Surgery is applicable to relatively few patients; and

prolonged if not permanent maintenance treatment is still not widely used unless previous symptoms were severe or there have been complications, and even then with considerable hesitation in younger patients.

Thus, even if more patients with ulcer disease were diagnosed, most would not be receiving treatment just before complications occur, either because there were no appreciable symptoms or because of prescribing practice, and it is unlikely that there will be any substantial change in the complication rate. If treatment policy changes, however, unless there is a massive reduction in the subsequent complication rate, it will be difficult to prove whether the treatment policy or an altered clinical course was responsible for the change.

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A lottery for life

SIR,—In the Yorkshire Television programme about which Dr A J Wing has written (10 August, p 492) Dr Miriam Stoppard explored the theme of doctors playing God in selecting patients for renal dialysis and transplant. I first heard of this programme in 1982, when the producer rang to ask if I knew of any eligible patients who had been refused dialysis. As it happened, I had a boy who was turned down at 18 and who was accepted only after something of a battle with the Cardiff renal unit. At that time three out of four applicants had to be refused, the criteria for selection were inevitably arbitrary, and, I think, equally inevitably, socially biased.

My patient was keen to take part if this

would help others in a similar plight, and this spring Dr Stoppard arrived with her travelling circus to film him and to interview me on the mountain against our village background. It was a fierce encounter on both sides. Dr Stoppard was interested in just one issue: how doctors choose who shall live and who shall die. I was interested in another: how society chooses that doctors must choose.

The cost of one Trident missile is about the same as our entire renal dialysis and transplant programme for one year, and one missile used in earnest would kill about a million people. Dr Stoppard regarded this as irrelevant to her theme. As pushing my patient on to the dialysis programme meant pushing someone else off,