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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Coaches on motorways

SIR,—The recent accident involving a passenger coach and several private vehicles must draw our attention again to the safety of public transport vehicles.

Successive resolutions at annual representative meetings have asked for the provision of seat belts for passengers in coaches. Unfortunately there has not been time for a full discussion of this issue, which is clearly a matter of deep concern.

On behalf of the BMA's board of science I have studied the available statistics for public service vehicles and have found that the mortality rate for passengers in coaches and buses is extremely low. For urban bus transport the provision of safety belts and requirement that passengers should be seated would so increase the number of buses on the roads that the accident rate to other road users would be seriously increased, nullifying the effect of using safety belts.

Recently the board of science received evidence from the Bus and Coach Council indicating that coach seats are now designed to provide cushioned deceleration of passengers in a head on impact. Parliament is considering regulations to provide greater structural integrity for coaches so that passengers are not injured in roll over accidents by the collapse of the roof of the coach.

What should be of concern to us, I suggest, is that buses and coaches are involved in more accidents resulting in deaths and serious injuries than private vehicles. Thus in 1983 buses and coaches were involved in 7·3 deaths per 100 million vehicle kilometres compared with 2·3 for private cars. On motorways the risk of a fatal accident is 3·1 per 100 million vehicle kilometres for buses or coaches and 0·9 for cars.

The root of the problem is that coaches, which are big and ponderous, are travelling at high speeds on motorways. Thus the Department of the Environment's statistics for road traffic accidents for 1983 state, "On single carriageways 17% of buses and coaches exceed 50 miles per hour, on dual carriageways 64% exceeded 50 miles per hour and on motorways 98% exceeded 50 miles per hour, 31% exceeded 70 miles per hour and 7% exceeded 80 miles per hour." At these speeds a coach is an extremely dangerous missile, as the fatality rate to other road users shows.

In some Continental countries a speed limit of 50 miles an hour applies and I would suggest that we press for such a limit on intercity coaches in Britain. Ultimately, of course, there is a clear rationale for letting the "train take the strain."

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The Southall Diabetes Survey: prevalence of known diabetes in Asians and Europeans

SIR,—We congratulate Dr Hugh M Mather and Professor Harry Keen (19 October, p 1081) on the hard work they put into the Southall diabetes survey and on their interesting results. It has been our impression that some diseases of the pancreas, especially acute pancreatitis, are more common in Asians than in Europeans. As we were one of three units that provided surgical care to some of the population covered in the survey, we were prompted to analyse our inpatient workload data to determine the frequency of three disorders—cholelithiasis, acute pancreatitis, and chronic pancreatitis—in different racial groups. Our review covers four years from January 1981 to December 1984, and this period includes the 1981 census and the diabetic survey of 1984.

We have collected data prospectively on all patients admitted to our care since 1981 and stored them on microcomputer disks for later analysis. The ethnic origin of each patient was recorded. Only those patients whose diagnoses were confirmed by laboratory and radiological studies, and

Numbers (and percentages) of people with cholelithiasis and acute and chronic pancreatitis in each racial group

	Asians	Europeans	Afro-Caribbeans	Others	Total
No (%) of patients seen	1479 (35·3)	2086 (49·8)	225 (6·1)	369 (8·8)	4189 (100)
No (%) with:					
Cholelithiasis	72 (4·9)	87 (4·2)	8 (3·1)	14 (3·8)	181
Acute pancreatitis	71 (4·8)	23 (1·1)	4 (1·6)	7 (1·9)	105
Chronic pancreatitis	31 (2·1)	12 (0·6)	2 (0·8)	3 (0·8)	48