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Correspondents are asked to be brief.

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"Marginal Surgery"—An Increasing Dilemma

SIR,—By "marginal surgery" I mean surgical operations which have passed the experimental stage and which, although established and mostly safe (though sometimes heroic), are on the margin below or beyond which they cease to be possible or desirable.

My own specialty of neurosurgery affords particular opportunity for this type of surgery, and the pressure from our colleagues to perform it can be considerable. However, I am becoming increasingly concerned about the consequences of these and other therapeutic procedures which may be conceived and performed with the highest altruism, but without the realization that the supporting services essential to the humanity of the total therapeutic exercise may have dwindled seriously in recent years and be insufficient to finish the job, or even to make the results tolerable.

Originally, these operations were carried out in the belief, indeed, often in the knowledge that, although they were unlikely to cure, a still palsied (but, one hoped, less so), a mentally dilapidated, or paraparetic patient would be reasonably well cared for in accommodation for the disabled or chronic sick, or by devoted relatives in his home. And if he died in the attempt, it could so often be reasonably said that, after all, "perhaps it was all for the best." Now, very few die in the attempt. There are not nearly enough beds for rehabilitation facilities to make the best of what was always a bad situation. Moreover, what social immunologists now call "rejection" by relatives is on the increase. At a recent meeting in Stoke Mandeville even there it was said that it is becoming more difficult to persuade relatives to shoulder the burden of a paraplegic; and the brain-damaged move insecurely between their homes and various institutions seeking some appropriate refuge or what, before the term became debased by connotation, was once called an asylum.

I am in no way belittling the real palliation that may be appropriately achieved by certain surgical procedures, nor am I asking for a moratorium on marginal therapy—indeed, perhaps only an overwhelmingly increasing demand will call forth money for the proper facilities for after-care. But I am anxious that the problem should be recognized and discussed; that judgement, selectivity and, above all, humanity should be exercised; and that specialist activity should be related now more than ever to the patient's total needs. What is it all for? And what is to become of him? To what extent has one's marginal surgery been underwritten?—I am, etc.,

JOHN M. POTTER.

Department of Neurological Surgery, Radcliffe Infirmary, Oxford.

Results of Vagotomy

SIR,—Your leading article (15 August, p. 358) suggests that vagotomy and pyloroplasty might be indicated for high lesser curve ulcers.

We performed this operation in 26 patients with gastric ulcer. In 12 the ulcer was above and in 14 below the incisura. The latter patients did well, only two having mild postoperative dyspepsia. Results in the 12 patients with ulcers above the incisura were disappointing. Four patients developed recurrent ulcer, four had dyspepsia, and four only were completely satisfactory. It is of interest that in one of the patients with recurrent gastric ulcer two years after the operation an associated duodenal ulcer had healed.

These results, indeed, are well in accord with current views on the distinction between high gastric ulcers and those lower on the lesser curve. The special nature of high gastric ulcers, especially their occurrence in stomachs with a high antro-fundic junction and a low acid potential, might be expected to render them unlikely to heal as the result of an operation designed to diminish gastric acid-pepsin secretion. Our results suggest that vagotomy and pyloroplasty, if it is indicated at all for gastric ulcer, should be reserved for ulcers below the incisura, and that it is contraindicated in high gastric ulcer.—We are, etc.,

GEORGE QVIST.
ADAM LEWIS.

London W.1.

Wrong Operations

SIR,—It is suggested in your leading article (22 August, p. 420) and by Dr. P. H. Addison (p. 461), that an indelible mark should be made on patients before they go to the theatre to indicate what operation is to be performed on what part of which patient.

I have never been happy about this suggestion. Who is to be responsible for placing this mark correctly? And will the surgeon be exonerated in the event of an error in the marking? Surely the surgeon, and only the surgeon, can be responsible for his work, including the onerous task of doing the right operation on the right patient, and any procedure which in any way relieves him of the need for vigilance can only be harmful and possibly misleading.