

# BRITISH MEDICAL JOURNAL

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## LEADING ARTICLES

Training Surgeons page 401      Tetracycline Diarrhoea page 402      Heavy Chain Disease  
page 403      Control of Measles page 404      Age and Joint Mobility page 405      Sulphur and  
Heart Disease page 405

## PAPERS AND ORIGINALS

<b>Occupational Toxic Factor in Mortality from Coronary Heart Disease</b> J. R. TILLER, R. S. F. SCHILLING, AND J. N. MORRIS .....	407
<b>Comparison of Side-effects of Tetracycline and Tc</b> REPORT TO THE RESEARCH COMMITTEE OF THE BRITISH TUB. TRIALS SUBCOMMITTEE.....	411
<b>Dysgammaglobulinaemia in Tropical Sprue</b> S. JARNUM, A. ....	416
<b>Rehabilitation of Patients with Through-knee Amputation</b> P. F. EARLY .....	418
<b>Auscultation of Foetal Heart Rate: an Assessment of its Error and Significance</b> EVAN DAY, LYNNE MADDERN, AND CARL WOOD .....	422
<b>Gastric Acid Secretion in Chronic Uraemia and after Renal Transplantation</b> J. C. GINGELL, G. P. BURNS, AND G. D. CHISHOLM .....	424
<b>Epidemiological, Clinical, and Biochemical Study of Endemic Dental and Skeletal Fluorosis in Punjab</b> S. S. JOLLY, B. M. SINGH, O. C. MATHUR, AND K. C. MALHOTRA .....	427

## PRELIMINARY COMMUNICATIONS

<b>Counteraction of Platelet Activity at Sites of Laser-induced Endothelial Trauma</b> K-E. ARFORS, H. C. HINT, D. P. DHALL, AND N. A. MATHESON .....	430
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## MEDICAL MEMORANDA

<b>Uncommon Complication of Anaphylactoid Purpura</b> J. S. FITZSIMMONS .....	431
<b>Meningomyelitis due to Brucellosis</b> M. G. SAHADEVAN, MAHINDER SINGH, P. P. JOSEPH, AND R. S. HOON .....	432
<b>Contralateral Pneumothorax with Congenital Diaphragmatic Hernia</b> D. G. YOUNG .....	433

## MIDDLE ARTICLES

<b>The Marie Curie Hospital 1925-68</b> ROBERT J. DICKSON	444
<b>Medical Education in the Federal Republic of Germany</b> WERNER RÖKEN.....	446
<b>New Appliances</b> Skin Temperature Measurement by Radiometry.....	448
<b>Personal View</b> JOHN MCKEE.....	449

## BOOK REVIEWS..... 441

## NEWS AND NOTES

<b>Epidemiology</b> .....	460
<b>Parliament</b> .....	461
<b>Medical News</b> .....	462

## CURRENT PRACTICE

<b>Patients with Drinking Problems</b> GRIFFITH EDWARDS	435
<b>Today's Drugs</b> Cytotoxic Agents in the Treatment of Malignant Disease.....	438
<b>Any Questions?</b> .....	440

## CORRESPONDENCE ..... 450

## OBITUARY NOTICES ..... 458

## SUPPLEMENT

<b>General Medical Services Committee</b> .....	35
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# Correspondence

Letters to the Editor should not exceed 500 words.

## Surgery for Perforated Duodenal Ulcer

P. F. Jones, F.R.C.S.; T. L. Kennedy, F.R.C.S. ....450

Registration of Nurseries and Child Minders  
H. H. John, D.C.H. ....451

Puerperal Thromboembolism  
D. G. Daniel, M.R.C.O.G., and others;  
D. G. Millar, F.R.C.S., and E. G. Robertson, M.R.C.O.G. ....451

Rare Cause of Precordial Pain  
C. Samaras, M.D., and others ....452

Unusual Cause of Yellow Skin  
Joan Yell, M.R.C.P., and others ....452

Folate Deficiency in Pregnancy  
B. M. Hibbard, F.R.C.O.G., and Elizabeth D. Hibbard, M.D. ....452

Herpesvirus hominis Infections  
P. S. Gardner, M.D., and Joyce McQuillin, F.I.M.L.T.; A. H. Tomlinson, D.Phil., and F. O. MacCallum, M.D. ....453

Accidental Poisoning in Childhood  
W. P. Sweetnam, M.D. ....453

Cardiomyopathy of Pregnancy  
Constance A. C. Ross, M.D. ....453

Infusion of Liver Tumours  
G. Falkson, M.D., and E. W. Geddes, M.B. ....454

Streptomycin and C.S.F. Sugar  
W. G. Bradley, M.R.C.P., and others ....454

Cyclophosphamide in Nephrotic Syndrome  
R. H. R. White, M.R.C.P., and M. W. Moncrieff, M.R.C.P. ....455

Malabsorption and the Skin  
Janet M. Marks, M.R.C.P., and S. Shuster, Ph.D., M.R.C.P.; N. H. Dyer, M.R.C.P., and J. L. Verbov, M.R.C.P. ....455

Acute Epiglottitis  
P. D. Phelan, M.R.A.C.P., and H. E. Williams, F.R.A.C.P. ....455

## Urinary Tract Infections

J. H. S. Hopkins, M.B., and others; R. Macis, F.I.M.L.T., and J. N. Ward-McQuaid, F.R.C.S. ....456

Hypnosis for Asthma  
D. Zimmerman, M.B. ....456

Sudden Death in Asthma  
G. M. McLaren, M.B. ....456

Conference Bureau  
D. W. Bracey, F.R.C.S.ED. ....456

Whose Patient?  
J. Ellis, M.B. ....457

Salaries for General Practitioners  
C. P. Wallace, M.B. ....457

Recognition for Seniority  
I. M. Segal, M.R.C.S.; J. A. Fraiss, M.R.C.S. ....457

New General Practice?  
A. Muir, L.R.C.P.ED. ....457

## Surgery for Perforated Duodenal Ulcer

SIR,—Mr. M. G. Machayya's careful study (19 October, p. 155) deals only briefly with two important matters in the surgery of perforated duodenal ulcer. He accepts Mr. J. A. Shepherd's (9 March, p. 625) statement on recurrence of symptoms after simple closure. Shepherd states that "it may be assumed that in any large series less than 25% of patients remain free from troublesome symptoms." From this, Mr. Machayya argues, it seems that every patient should have definitive surgery.

In 1953 I decided to test the theory that patients with perforated duodenal ulcer with a short history of indigestion probably had an acute ulcer which, if sutured, would give no further trouble, while those with a history of chronic indigestion could be assumed to have a chronic ulcer and should be treated by partial gastrectomy. This trial was continued for two years, during which 34 patients with a perforated duodenal ulcer were treated. Eighteen were considered to have an acute ulcer and had the perforation sutured, while 16 had a Polya gastrectomy for a chronic ulcer. One 87-year-old man died after simple suture. The patients were followed up four years later.<sup>1</sup> In the acute ulcer group, four had required further surgery, three had died from medical diseases after being free of indigestion for two to four years, and 10 had remained well and free of indigestion. In 13 out of 17 patients the decision to practise simple suture had, I believe, been fully justified. This small series only underlines the results of much larger ones in which the results of simple suture of acute ulcers have been assessed.<sup>2,3</sup>

I feel, therefore, that Mr. Machayya is on very doubtful ground when he argues that

definitive surgery is indicated for all perforated duodenal ulcers. Vagotomy is an operation with certain immediate and late complications, and these should not be bestowed on patients who do not need to suffer them.

There is a further important point. Emergency surgery is very largely practised in Great Britain by staff receiving their surgical training. If vagotomy and pyloroplasty is to become widely adopted, it means that this operation may well be performed by those who have not yet completed a thorough grounding in elective gastric surgery. This is not in the interests of patients. If definitive surgery is to be done, then it must be performed by experienced surgeons. As surgery is currently organized, these may well be consultants or senior registrars who already lose as much sleep as they can afford.

I remain a firm believer in definitive surgery for those patients with a perforated duodenal ulcer who have a long history of indigestion and are fit for the operation. They are always delighted when they learn that the operation was designed to prevent further trouble. But I believe careful judgement should be exercised in selecting these patients; this judgement must include an assessment of the experience of the surgeon.—I am, etc.,

Aberdeen.

PETER F. JONES.

## REFERENCES

- 1 Jones, P. F., *Postgrad. med. J.*, 1960, **36**, 768.
- 2 Gilmour, J., *Lancet*, 1953, **1**, 870.
- 3 Noordijk, J. A., *Acta chir. neerl.*, 1953, **5**, 262.

SIR,—Mr. M. S. Machayya has shown (19 October, p. 155) that truncal vagotomy and pyloroplasty can be carried out safely, and with good immediate results, in the management of perforated duodenal ulcer within the first six hours provided that the patient is not too old. He has not, however, shown that this operation is necessarily desirable.

He states that about 75% of those treated by simple suture will subsequently have further symptoms, and that most of these will require further definitive surgery. Professor A. W. Kay,<sup>1</sup> however, gives a figure of less than half requiring further operation. Most surgeons would probably accept a figure of 50%. A policy of indiscriminate vagotomy for all cases of perforated duodenal ulcer would thus mean an unnecessary denervation in about half the patients. This would be of little moment, provided that there was no increase in the immediate mortality, and that there were no undesirable side-effects of either vagotomy or pyloroplasty. Unfortunately, dumping, diarrhoea, and other disorders of intestinal, pancreatic, and biliary function do occur all too frequently. To produce crippling diarrhoea in a young man with an acute duodenal ulcer would be a disaster.

Some, at least, of the poor results of vagotomy are due to defects of the patient's personality. The experienced surgeon tries to exclude psychiatric and personality problems before recommending definitive surgery for ulcer, but in the patient with acute perforation a proper assessment of the patient's personality is obviously not possible. All of Mr. Machayya's patients were treated by truncal vagotomy, but an increasing body of surgical opinion favours the more sophisticated selective or gastric vagotomy, an operation which requires more time and more