than was the case 10 years ago. The point at which the person is in "need" of residential accommodation when only five-day care is available is at a level of disability lower than that when two or three visits a day are also available on Saturdays and Sundays.

Because domiciliary services have developed without a corresponding increase in staffing ratios in residential homes it is now common in many parts of the country for elderly people to be able to be kept at home until they are past the level of acceptability for residential care. Another example of this paradox is the frequent discharge of people from hospital to their own homes who are deemed unfit for part III accommodation.

A survey conducted by Dr John Rodgers and myself, with the support of the Association of Directors of Social Services, has revealed that many authorities are evolving new types of residential care for more dependent people. It is surely now time, however, to accept the fact that we have long-stay hospital wards and residential care as two separate institutions merely as an accident of history. We need a new type of institution, jointly run by health and social services, caring for the full range of disability and dependency that is met in old age, which is able to support the old person who has to leave her home near that home and her community for the rest of her life.

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SIR,—One possible solution to the questions asked by Sir George Godber (3 April, p 1040) about where to place new capital investment in the spectrum of community services, sheltered housing, local authority sheltered accommodation, and hospital services for the elderly is at both ends. In my view, improved community services at one end and improved hospital services at the other should minimise—but not eliminate—the need for much increase in the middle. As Dr C J Turnbull (3 April, p 1041) points out, home is by and large better than any form of institution, and psychiatrists realised this some years ago in adopting the policy of running down the vast asylums in which unfortunate persons were kept, often indefinitely. The analogy is not exact—but the principles are the same.

Even in the case of the desirable sheltered housing it is important that new units should be in small groups and in contact with the rest of the community—and not in large isolated groups. Contact with younger people usually helps the old and lessens the feeling that they are some kind of different being.

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Special doctors for rape victims

SIR,—A letter (20 February, p 600) suggests that special doctors are designated to interview the alleged victims of rape. You will recall that your leading article (25 January 1975, p 171) stated: "In the larger urban areas the police have a team of women doctors who specialise in sexual assault on women and children."

Recent correspondence in the *Daily Telegraph*, however, has suggested that these units

do not exist.¹ Some clarification would be welcome.

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¹ Roberts REI. *Daily Telegraph* 1982;Feb 2.

*In the Metropolitan Police area it is no longer the practice to call automatically a woman police surgeon to a victim of sexual assault—whether it is a woman or a child: a woman doctor is found if the victim (or in the case of a child the parent or guardian) asks for one. Provided that the doctor understands all the emotional as well as forensic problems, there is rarely any difficulty experienced because he is a man. There is, of course, always a woman police officer present. —Ed, *BMJ*.

Incidence and detection of occult hepatic metastases in colorectal carcinoma

SIR,—In their study of the development of hepatic metastases from colorectal carcinoma, Mr I G Finlay and others (13 March, p 803) had two purposes. Firstly, they aimed to establish the incidence of "occult" metastases which they presumed were present in the liver but undetectable at the time of surgery. Secondly, they have compared the sensitivity and specificity of imaging methods in the detection of these metastases.

Assuming that the operative procedures at laparotomy on their patients were so called "curative" resections, any metastases developing subsequently must have grown from seedlings that had already spread at the time of surgery. The finding of occult metastases in 26% and an overall metastasis rate of 40% in the whole group in a two-year follow-up is in keeping with other studies.¹⁻⁶ Such data are a valuable addition to our knowledge of the natural history of the disease. It is of particular importance in the selection of patients for chemotherapy and in the evaluation of their response to treatment.⁶

It is unfortunate that the three imaging techniques being compared were used only serially when there were other reasons to suspect the presence of hepatic metastases. Obviously, routine serial imaging with techniques involving ionising radiation would not be justified without reasonable clinical indications. Even then, isotope scanning was extremely poor, and ultrasound scanning was not good at demonstrating the lesions in these patients with subsequently proved metastases. The authors do not state at what stage in the development of the occult liver metastases these techniques were compared. Certainly in the later stages of metastatic growth a better detection rate than 1/11 for isotope scanning⁷ and 3/11 for ultrasound scanning would be expected.⁵⁻⁹

The methods of performing isotope liver scans and computerised tomography are standardised and relatively straightforward, though the interpretation of the images still requires expertise. By contrast ultrasound scanning requires considerable practical and conceptual skills. Consequently, the thoroughness of the scan, the quality of the image, and its interpretation all depend very heavily on the ability and aptitude of the operator. Ultrasound scanning, however, has the great virtue that it is safe and can be repeated as often as necessary.

It is also acceptable and well tolerated by patients as part of their routine postsurgery follow-up.

In a long-term prospective follow-up study of patients who have had resections of colorectal carcinoma, I have been performing ultrasound scans of the liver at three-monthly intervals.¹⁰ There are now 95 patients in the study with a median follow-up of more than two years. The percentage of patients with subsequently proved hepatic metastases in an interim analysis at 15 months was 18%. All of these were detected ultrasonically. Ten per cent of the patients had "occult" metastases according to the criteria of these authors. A two-year analysis is in progress.

The particularly interesting feature of our study has been the value of ultrasound in the early detection of hepatic metastases. In all instances metastases were seen on ultrasound scans 3-6 months before there were symptomatic, clinical, or biochemical features suggesting their presence. For this reason I would suggest that serial ultrasound scanning of the liver should be incorporated into the routine follow-up procedure for such patients in any prospective study. Though some scans may be technically unsatisfactory the technique has a high specificity, as these authors have shown, and with experience the sensitivity can also be high.⁷⁻⁹

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¹ Mayo CW, Schlicke CP. *Surg Gynecol Obstet* 1942;74:83-91.

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³ Gunderson LL, Sosin H. *Cancer* 1974;34:1278-92.

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⁷ Bryan PJ, Dinn WM, Grossman ZD, Wistow BW, McAfee JG, Kieffer SA. *Radiology* 1977;124:387-93.

⁸ Taylor KJW, Carpenter DA, Hill CR, McCready VR. *Radiology* 1976;119:415-23.

⁹ Lamb G, Taylor I. *Gut* 1980;21:A902-3.

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Duodenogastric reflux: is there any progress?

SIR,—I read with interest the leading article on duodenogastric reflux (20 March, p 845), but I must take issue with Dr D G Thompson concerning some of his conclusions.

It would be wrong to conclude that there is no practical significance to finding bile in the stomachs of unoperated patients simply because we cannot explain its presence there. Duodenogastric reflux can cause marked functional^{1,2} as well as morphological changes³ in the intact stomach, and these changes cannot be ignored. The functional effects of such reflux appear to be a specific property of refluxing duodenal contents as they do not occur with intragastric biliary diversion alone.¹ Therefore, the finding that gastric mucosa adapts to the presence of bile salts⁴ is not a valid argument against the significance of duodenogastric reflux. Furthermore, the findings of high concentrations of bile acid conjugates, sodium, and lysolecithin in the gastric juice of patients with peptic ulceration, combined with the evidence of reflux provided by Capper's pyloric tube test and more recently M-(2,6, dimethylphenyl carbamoylmethyl) iminodiacetic acid scanning, suggests that the coexisting antral gastritis and functional changes observed in these patients are not

simply coincidental. Indeed, a detailed study of these changes observed in such patients has led to the hypothesis that duodenogastric reflux plays an important part not only in the pathogenesis of gastric ulceration but also in that of duodenal ulceration.⁵

Another vital consideration is the role of such reflux in the postgastrectomy patient. It undoubtedly produces marked endoscopic and morphological changes in the stomach, many of which can be reversed by a Roux-en-Y procedure. The change that causes most concern, however, is that of dysplasia.⁶ There appears to be a poor relation in many cases between symptomatic and endoscopic and histological findings, but this wide individual variation in symptomatic response should not distract our attention from the potential malignant hazards of severe dysplasia developing in the gastric remnant many years after gastrectomy. Therefore, some patients may well require "anti-reflux" surgery not only to improve their symptoms but also to halt progressive dysplasia.

I agree thoroughly with Dr Thompson that more knowledge about the pathophysiology of duodenogastric reflux is required, but, meanwhile, I am not prepared to ignore the practical significance of finding bile in the stomach. I believe that progress is being made in this field and that evidence is mounting that may well incriminate such duodenogastric reflux in the pathogenesis of a wide variety of clinical conditions.

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⁴ Scheurer UC, Schlegel JF, Kelly DG, Code CF. *Scand J Gastroenterol* 1981;16, suppl 67:205-10.

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Dangerous cots

SIR,—We were interested in the reports of "Dangerous Cots" by Dr P R Langley (30 January, p 351) and Dr M A Woodhouse (20 February, p 596), and wish to report another fatal accident caused in a similar way.

A baby of 14 months was put in his cot at 7 pm one evening in 1979 and the following morning was found dead, suspended by his cardigan which had become entangled on the cot-side guide rod. It was thought that he had been standing up in the corner of the cot when the cardigan became entangled and that in his efforts to get free he had fallen over so that the cardigan had cut into the side of his neck. At necropsy he had all the classical signs of an asphyxial death, with a constriction mark 13 cm long and 0.5 cm deep over the front and side of his neck.

The cardigan was made of open-weave non-stretch nylon, and the metal rod protruded about 2.5 cm up above the level of the wooden cot side. The enclosed photograph shows the cot end with some of the cardigan still present on the metal rod. The irony of the transfer picture on the end of the cot will be noted.

The BSI Standard BS 1753 (1977), "Safety Requirements for Children's Cots," states that: "There shall be no constructional details such as projections, holes, loose washers, speed fixing, nuts, crevices, etc, on which the child's clothing or body could become

Cot end showing protruding rod and a piece of the dead baby's cardigan.

snagged or trapped," and that: "It shall be impossible to unscrew or loosen except by the use of a tool (for example, screwdriver, key, or coin) any part of the system for guiding the dropside."

There would appear to be two main factors in these cases: (a) the fact that the metal rod protruded above the level of the dropside of the cot (which could be due either to the rod not being properly screwed down or to the cot side not being properly pulled up); and (b) the open-weave nature and the non-stretch nylon material in our case. The problem of the cot side is one of human error, and as the BSI Standard seems satisfactory there is little that can be done about this other than drawing mothers' attention to the importance of not leaving any part of the bar protruding, but the problem of the dangers of open-weave nylon cardigans for small babies might possibly be solved by banning their use for children under 5 years of age.

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Elective surgery after myocardial infarction

SIR,—Dr R W Portal's leading article (20 March, p 843) which asks "whether patients are fit for surgery" really implies "fit for anaesthetic." I have always been intrigued by the request made to a physician regarding a patient's suitability for an anaesthetic. It is a part of an anaesthetist's training to assess preoperative patients as is shown in the final examination for the fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons.

As a surgical apprentice, I could never understand why, time and again, I had to request a physician (in the process of just carrying out my instructions) to tell us if a particular patient was fit to be anaesthetised or not for an elective operation. On most occasions the sum total of the advice from the physician amounted to: "Things should be OK if you keep the blood pressure up and give enough oxygen."

I hope anaesthetists will stop this insulting procedure of being told by one without any anaesthetic training who is fit for an anaesthetic and who is not—an opinion which they are (or should be) best suited to give in the vast majority of patients. It is only a very small minority of complicated problems in cardio-

vascular surgery that need a joint assessment by an anaesthetist and a physician. There are anaesthetic assessment clinics in some district general hospitals run very efficiently by anaesthetists and hopefully this practice will catch on.

Although it would have been more appropriate coming from an anaesthetist, I have learnt much from this excellent leading article.

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Chronic inflammatory bowel disease in childhood

SIR,—We are grateful to Dr D H Shmerling (13 March, p 825) for the opportunity to clarify some points emerging from our article on chronic inflammatory bowel disease in childhood (9 January, p 101). First in our flow diagram, the dotted line from Crohn's disease to barium follow-through was only dotted for artistic reasons, and our text states: "If Crohn's disease is diagnosed on endoscopy or histologically a barium follow-through study is necessary to confirm or refute accompanying small-bowel disease." For clarification we should perhaps have used a straight line.

Secondly, our arrow from "definitely abnormal" to "colonoscopy" appears in both directions but should also be in both directions from "definitely abnormal" to "barium follow-through," although again our text states: "If the small bowel is shown to be abnormal radiologically, colonoscopy is the next examination of choice to provide histological confirmation by biopsy of the terminal ileum and to show any colonic disease."

Finally, we are uncertain that all children suspected of having small intestinal Crohn's disease whose barium meal follow-through is normal should automatically undergo colonoscopy. We would recommend close follow-up with a view to colonoscopy if symptoms persist.

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Do general practitioner deliveries constitute a perinatal mortality risk?

SIR,—Dr Nicholas Black's paper on the safety of delivery in GP units (13 February, p 488) made pleasant reading, and I would agree with many of the comments subsequently made. GPs need to retain involvement in intrapartum affairs if the patient is going to get the full benefit of general practitioner obstetrics.

Mr E J Shaxted (13 March, p 822) makes a very important comment that the perinatal figures do not always reflect the true situation in that any woman with an intrauterine death is delivered in hospital. I would also add, having worked in the Nottinghamshire area, that one flying squad call that I had was to a patient with shoulder dystocia with a delivery on my arrival of a baby without an audible fetal heart or any form of respiration. That child was resuscitated and taken back to the hospital, but if it had subsequently died it would have been on the hospital's books.

To finish, I would like to make the point that not all areas are served by a flying squad; although obviously most units retain the