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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 must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Deployment of mental handicap specialists

SIR,—The number of specialists in mental handicap is falling as consultants retire and few young doctors are attracted to specialise entirely in mental handicap. Sooner or later this must force a change in the pattern of consultant provision for this subspecialty.

It is contended that a large proportion of the residents in existing hospitals for mental handicap do not strictly need psychiatric care. For a consultant to be held responsible for hundreds of patients whom he is able to see in practice for only minutes in a year is unfair to the specialist and to the patients. Instead of being appointed to hospital bases, consultants in mental handicap should be appointed to an area or district and given a broader brief. This should include an advisory role and cover

community and hospital facilities. Instead of being in charge of hundreds of patients in a hospital, the specialist should be allowed to fulfil a more truly consultant role for those mentally handicapped people who need consultant psychiatric advice, whether they are in hospitals or hostels or living at home.

This arrangement would have the advantage that it would be a more economic and efficient use of limited consultant manpower. Such a change might help to revitalise a dying specialty and by offering new opportunities and challenges attract more recruits.

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Gastric and duodenal ulceration after burns

SIR,—Your leading article (1 September, p 512), noting the frequency and importance of ulceration of the stomach and duodenum after burns, refers to the use of antacids in prevention of this condition and to the need for further studies "since we know little about how this occurs."

The role of acid in this condition must surely be a secondary one, since at least during the first few hours after burns intraluminal gastric acid is reduced, yet it is at this stage that congestion and mucosal erosions occur. It appears that there is loss of mucin from the

goblet cells, perhaps related to the high blood cortisol level after shock, and it is this depletion of the protective layer which makes the mucosa vulnerable to even small quantities of acid. Stress erosions are thus more related to depletion or even to chemical changes in gastric mucin than to alterations in the pH of the gastric juice.

It has been suggested that the use of H₂-antagonists may even act adversely in this respect.^{1,2} Surely more studies are needed to find some means of increasing or changing the protective mucin of the stomach rather than to

reducing the level of acidity. Very early treatment to stimulate mucin production, or even routine treatment *before* severe trauma such as major surgery, would appear to be a more hopeful approach, and controlled studies on these lines, as have been suggested,³ might lead to interesting results.

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¹ Guslandi, M, *et al*, *British Medical Journal*, 1978, **1**, 1486.

² Guslandi, M, *Lancet*, 1978, **1**, 1267.

³ Hunt, T, *South African Medical Journal*, 1969, **43**, 1443.

Opiates in acute abdominal pain and head injury

SIR,—I would like to support the suggestion made by Mr J C Angell (25 August, p 485) in his excellent review of the 15th edition of Cope's *Early Diagnosis of the Acute Abdomen* that we reconsider the stringent prohibition of opiates before diagnosis in cases of acute abdominal pain. As Mr Angell says, this prohibition causes much agony to the patient; and I find it difficult to believe that it really interferes with the diagnosis to the extent that is maintained by some surgeons.

While the problem of analgesia in abdominal pain is being reviewed, perhaps the time has also come to review the prohibition of opiates in cases of minor head injury. It can be difficult, if not impossible, to assess properly cases of multiple injury without adequate analgesia.

The alternative to opiates is Entonox, but in my experience this has never been as effective.

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Effect of beta-blockers on arrhythmias

SIR,—In their report Dr J M Roland and others (1 September, p 518) conclude that beta-blockers have no effect in preventing "serious" arrhythmias in the acute phase after myocardial infarction. It is possible that their results may have been affected by the following factors.

Firstly, the recordings were obtained quite late after chest pain (mean of 17 hours in placebo and atenolol-treated groups and 18 hours in the propranolol-treated group). The incidence and frequency of serious arrhythmias is considerably lower than in the earlier hours.¹ It is possible that in patients in whom recordings were obtained earlier (say under 12 hours after chest pain) there is a greater chance of showing a benefit. This may have been missed by the late onset of tape recording.

Secondly, the use of oral beta-blockers may have led to inadequate blood levels in the first 24 hours. This has been shown to occur with propranolol² and we have seen this with atenolol (unpublished data). Therefore the use of oral preparations would have further decreased the chances of showing a benefit. This is important, as tape recording may well have finished before effective beta-blockade was achieved in some patients. The delay in adequate beta-blockade would increase still further in the atenolol group, where a third of the patients would have received placebo as the first tablet.

The authors report a significant fall in maximum heart rate over the first 24 hours as evidence of adequate beta-blockade. This shows that beta-blockade was achieved some time over the first 24 hours. It would be more relevant to know the time of onset of a "significant bradycardia."

The authors state that serious arrhythmias occurred in similar numbers of patients in both groups. They do not state whether the frequency of these arrhythmias in each patient was less on treatment or on placebo. We agree that it may prove impracticable to analyse episodes, "as the results can be too heavily biased by individual patients" if standard *t* tests are used. However, this may be overcome by using simple non-parametric tests such as Wilcoxon's rank test or by using the log values prior to using standard *t* tests.⁴

A recent paper³ has demonstrated that earlier intravenous administration of acebutolol (6 hours after the first rise in creatinine phosphokinase) decreased ventricular arrhythmias and is at variance with the study of Dr Roland and his colleagues. Although this may be due to the different beta-blocker used, it is highly likely that the difference in methodology is responsible.

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¹ Adgey, A A J, *et al*, *Lancet*, 1971, 2, 501.

² Rutherford, J D, *et al*, *Clinical and Experimental Pharmacology and Physiology*, 1976, 3, 297.

³ Ahumada, G G, *et al*, *British Heart Journal*, 1979, 41, 654.

Large-bowel obstruction caused by cancer

SIR,—Mr L P Fielding and others (1 September, p 515) are right to keep alive the unresolved and controversial matter of the best treatment for large-bowel carcinoma presenting with obstruction. Their figures bear out what has always been suspected, that the skill and experience of the surgeon and the conditions under which he operates are of undoubted significance. Until a larger series has been collected and a more generally accepted definition of "acute obstruction" found results cannot be evaluated.

What is of special interest is that primary resection *without* primary anastomosis, a procedure advocated by me as long ago as 1960,¹ is now being practised. This small series of 24 cases so treated carried a 33% mortality. If this third option were more widely practised it is possible that the figure would improve.

In view of the great number of variables involved, a larger number of cases must be studied, thus enabling comparison to be made not only between the classical staged procedure and primary resection with immediate anastomosis but also primary resection with delayed anastomosis.

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¹ Sames, C P, *Lancet*, 1960, 2, 948.

SIR,—I read the article on the management of large-bowel obstruction caused by cancer by Mr L P Fielding and colleagues with interest (1 September, p 515). However, I do not feel that their conclusions are valid on the data presented in this article. Surely it is necessary to define the causes of mortality after surgery before concluding that the surgeon, trained or otherwise, is responsible for that mortality.

With respect to the arguments for and against primary tumour resection, I think most surgeons would agree that the tumour should be excised if this can be done without increasing the risk to the patient. This need not involve an immediate anastomosis, and I would be interested to know how many of the 19 deaths in the primary resection group were due to anastomotic leakage.

The 31 patients treated by staged resection fared well, with only two postoperative deaths. Of the remaining 16 patients in this group, 11 died and presumably several if not most of those died of causes unrelated to their surgical or anaesthetic management. It is my contention that such deaths would probably have occurred irrespective of the type of surgery undertaken.

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*. We sent a copy of this letter to Mr Fielding, whose reply is printed below.—ED, *BMJ*.

SIR,—Thank you for allowing us to comment on Mr C G Marks's letter; we have tried to answer the five points raised.

The problem of who is "responsible" for the death of any patient, particularly in a group of patients who are often seriously ill, is usually a difficult and sometimes a sensitive issue. The

suggestion that to identify a cause of death is to be able to apportion responsibility for that death may be attractive, but is too simplistic a viewpoint and is not supported by our experience of the outcome of mortality conferences, especially in the context of complex patient management. The causes of death in our study are set out in the accompanying table.

Causes of death after primary and staged resections for large-bowel cancer

Cause of death	Primary resection group (n = 90)	Staged resection group (n = 47)
Sepsis	8	5
Cardiorespiratory .. .	3	3
Bronchopneumonia .. .	2	2
Pulmonary embolism .. .	1	2
Carcinomatosis .. .	2	1
Cerebrovascular accident .. .	2	0
Burst abdomen .. .	1	0
Total	19	13

Mr Marks's suggestion that most surgeons agree that immediate resection for obstruction is the treatment of choice is, sadly, not our conclusion. On the contrary, it is clear that primary resection for obstructing left-sided tumours remains controversial that colostomy being said to be simple and safe in sick patients even for the inexperienced surgeon. Our data suggest—only suggest—that this is not the case.

Anastomotic leakage is often difficult to define, especially when postoperative radiological investigation is omitted. In the primary resection group one-third of the deaths were probably attributable to anastomotic leakage.

Of the 16 patients in the staged resection group who in fact had only a stoma, 11 died; only three of these deaths (two pulmonary emboli, one bronchopneumonia) could be said not to have been a direct consequence of the surgical or anaesthetic management. Furthermore, one could argue that all 18 (38%) of these patients (13 deaths and five no resection) had "failed treatment": a statistically higher rate than in the primary resection group (19/90, 21%; $P < 0.05$).

Although it is Mr Marks's contention that these deaths would have occurred anyway, it seems to us common sense that the greater experience of a senior surgeon would be of benefit both to these patients, who are frequently ill, and (dare we say it?) to the instruction of the surgeon in training. If this is not the case what is the meaning or utility of "clinical experience"?

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Fetal malnutrition—the price of upright posture?

SIR,—I was very interested in the hypothesis advanced by Dr André Briand (4 August, p 317) and my recent experience in a developing country is relevant.

I am currently employed by a mining company in Zaire as a general practitioner with the responsibility for health and welfare of the whole local population of approximately 60 000. The local community consists largely of subsistence farmers growing mainly rice, cassava, and groundnuts. There is virtually no