Haemorrhoids and a high-fibre diet

SIR,—I read "Prospective trials of minor surgical procedures and high-fibre diet for haemorrhoids" (20 October, p 967) with interest. Mr M R B Keighley and his colleagues concluded that a high-fibre diet was of little value in the management of haemorrhoids. They came to this conclusion after giving patients a high-fibre diet sheet and four Fybranta tablets daily. Each tablet contains 2 g of bran, so that the daily dose was 8 g. This is about half the amount that is required by the average patient to render the stools soft so that they are voided without straining. The makers of Fybranta (Norgine) recommend 6-12 tablets daily. In practice, patients and their diets vary and so each patient has to find the amount of bran that he or she requires to open the bowels without straining. Some need several tablespoons a day. Few benefit from as little as 8 g of bran daily.

There is no doubt that a high-fibre diet relieves the symptoms of early haemorrhoids and makes the postoperative course following dilatation or haemorrhoidectomy more comfortable. Hence it would be a pity if the value of bran in the treatment of haemorrhoids were to be discredited because insufficient bran was given to the patients in this study.

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SIR,—With the support of my general surgical colleagues, I tried to use some beds of a general surgical allocation for the treatment of patients on a one-day basis over the two years 1975-7. I am now retired and the figures are not readily available to me, but these are scarcely relevant to the points I would like to emphasise.

Information and liaison are the top priorities. General practitioners were invited to comment about the scheme before it was started. The response was generally favourable but there was some fear of calls, especially at night, when perhaps little or no information would be available about the treatment undergone by the patients. It requires scrupulous attention to detail to obviate this difficulty. (1) The general practitioner's agreement should preferably be obtained when a patient is to be selected. (2) The practice should be informed 48 hours before the patient is due to attend. (3) On completion of operation a letter or form typed or filled in legibly should be posted *first class* not later than the last post of the day. There is no place for the economy of letter pooling for postage.

I thought at first that it would be justifiable in straightforward cases to ask the patient or a relative to take a note to the GP's surgery but this is fraught with risks. It may be necessary to telephone to give more certain early information in some cases.

A form should be as simple as possible but cover details of operation, anaesthetic, likely contingencies, and arrangements for removal of sutures or follow-up. After each minor operation there is pressure to get on with the next case; and even with good secretarial assistance, which I had, ensuring proper completion of a form giving adequate early information was the biggest problem owing

to changing junior surgical staff, sometimes not conversant with practice in the UK.

Operative failures or complications cause alarm, irritation, and embarrassment so that the emphasis in operative technique is primarily on care. Reasonable speed comes with practice but haemostasis must not be sacrificed to achieve this. Accommodation was provided in a main ward or a side ward. Occasional difficulties arose when nursing staff changed and were not fully informed of the procedures. Patients were enthusiastic; but selection had to take account of all the circumstances, of which available transport was probably the most important. Much reliance was placed on friends or relatives.

Owing to a changing "on-take" rota for emergencies, a regular day could not be set aside. To achieve results proportionate to the effort involved, it is essential to form a special unit on the lines adopted by the Western General Hospital, Edinburgh (22 September, pp 712 and 714), with regular staff and secretary so that all parties have a full understanding of what is involved. But the scope for this sort of treatment is enormous.

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Inflammatory bowel disease in the West Indies

SIR,—The recent article by Professor Courtenay Bartholomew and Mr Alan Butler (6 October, p 824) reporting the finding of 34 cases of ulcerative colitis and 14 cases of Crohn's disease in indigenes of Trinidad and Tobago over a 10-year period is interesting. However, the title "Inflammatory bowel disease in the West Indies" is misleading since their data relate only to a single country.

Trinidad and Tobago are small islands in the extreme south of the Caribbean; the former is situated six miles from the South American mainland. Observations made in these islands may not reflect the situation elsewhere. Pockets of disease are known to exist in the West Indies—for example, yellow fever in Trinidad, schistosomiasis in St Lucia and Puerto Rico, and tropical sprue in Puerto Rico, Haiti, and the Dominican Republic.

No cases of Crohn's disease have been reported from Jamaica to date, although ulcerative colitis has been found.¹ I have heard of one patient from Barbados with Crohn's disease, but know of no case reports from other West Indian countries. The patchy geographical distribution of Crohn's disease worldwide is well recognised. This solitary paper from Trinidad should stimulate more careful case documentation and epidemiological research in the Caribbean.

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¹ Terry, S, and Raju, D, Abstract from 22nd Scientific Meeting of the Commonwealth Caribbean Medical Research Council, Belize, 1977.

To skip judiciously

SIR,—It is no doubt a privilege to have one's work reviewed by your distinguished journal (3 November, p 1133). I wonder, however, whether your distinguished reviewer George Komrower has not confused two quotations.

He quotes Disraeli as having said that "the art of reading is to skip judiciously." The *Oxford Dictionary of Quotations* (2nd edition) attributes this to Philip Gilbert Hamerton. On the other hand Isaac D'Israeli is quoted as saying, "There is an art of reading as well as an art of thinking and an art of writing."

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Beer as prevention for runner's haematuria

SIR,—Your leading article on runner's haematuria (21 July, p 159) contains no information on its prevention. It was present in 18% of our members after a recent Boston marathon.¹ Those of us who have run over 100 marathons have empirically used beer to prevent this condition. It appears exclusively in its "benign" form in non-drinkers of beer; however, haematuria in two beer-drinking runners was found to be due to malignancies.

The benign form of runner's haematuria follows exercise-induced renal shut-down—either as ischaemic renal injury or as bruising of the empty bladder. Usually this is self-limited; however, it has resulted in at least one death in the United States. The runner, in his 20s, had multiple episodes of dark urine in training. Urological studies gave negative results. However, he developed renal shut-down in his first marathon and expired a week later (1 September, p 547).

The diuretic effect of one litre of beer appears adequate to protect a runner during a 40 kilometre run if he has no past history of haematuria or urinary calculi. However, if there is a history of one of these conditions a litre of beer should be used for each 20 kilometres.

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¹ Siegel, A J, et al, *Journal of the American Medical Association*, 1979, **241**, 391.

Routine exercise testing using bipolar-CM_s-lead recordings

SIR,—A recent letter by Drs P A Poole-Wilson and A F Rickards (29 September, p 794) commented on work reported by Dr J A Raffo and others (7 August, p 295). Dr Poole-Wilson and Dr Rickards say, "a fairer assessment of the clinical value of the test studied should include the 32 patients who were excluded. The results would then be less favourable." Such a conclusion cannot be made and was possibly a result of not properly understanding the report. There were 36 patients with indeterminate tests, only six of whom could be made available to a physical training programme so as to allow a proper test—that is, their heart rate after training could be raised to a high enough level to complete the test. "Indeterminate" means the test cannot be completed and therefore they should not be included.

There remains their suggestion that a 12-lead recording system for the electrocardiogram compares favourably with bipolar-CM_s recordings and they claim they have shown, "that in patients with angina pectoris