tablets that they are asked to swallow. Many are small and white and easily confused with others. Others are difficult or unpleasant to take. These difficulties may be compounded by the patient's having no understanding about why he is given treatment, and we end up with a situation in which it is highly likely that the patient will not comply with the doctor. The tendency is to blame the patient, whereas the real problem is that the instructions that the patients are given are not right and what we have asked them to do may be impossible, or at best difficult.

The answer to this problem is to question everything we do as practising clinicians, to stop and listen to what patients say, because often they will tell us the answers but we do not hear what they say. Finally, we should spend time talking to them and explaining what the treatment is, how we think it should be taken, and what benefits will accrue, basing all these things not just on beliefs but on evidence.

D C BANKS

University Department of Therapeutics,
City Hospital,
Nottingham NG5 1PB

Day-bed surgery

SIR,—In reply to the letter about day-bed surgery by Mr Douglass Vellacott (17 November, p 1293), I feel that there are many operations more major than the traditional varicose veins and piles that could be done on a "day-bed" basis, given an intelligent relative to nurse the patient at home and an accessible district nurse.

The patient could leave hospital the day after operation so long as drips were down, fluids being tolerated, subcutaneous heparin completed, and analgesia adequate. He should be given a letter for the district nurse, and a supply of paracetamol, bisacodyl, and dressing. He would need to have been taught his breathing exercises by the physiotherapist prior to discharge, and the relative and nurse would nag him to do these. If the household had no thermometer perhaps one could be loaned. Each day the district nurse would check the wound for infection, likewise any other possible infections such as chest and drain sites, inquire about eating, sleeping, and pain relief, and restoration of bowel function (this includes attempting to deal with the painful problem of wind, as well as laxatives). Then she empties the tablet bottles to count the remaining tablets, and checks that the patient is taking his tablets, and lastly looks for any developing anaemia or deep-vein thrombosis (DVT). (The initial letters of wound, infection, drain, eating, sleeping, pain, restoration (of bowel function), empties (tablet bottles), anaemia, and DVT spell the mnemonic WIDESPREAD.)

It would be interesting to hear from anyone who has already attempted to do this at home, and to learn whether hospital doctors are obliged to remove the stitches, or whether this can be entrusted to district nurses. The morale of the patient and his incentive to get up and get better must be stronger at home, and the staphylococci might even be penicillin sensitive. The beds that are emptied in surgical wards maybe could be used to help to deal with the orthopaedic waiting list, and if the teaching hospitals could set an example in this charitable business of empire-eroding the rest of the country would surely be willing to

follow suit. In the end the prestige of the empire-eroding surgeon might even be enhanced.

ELIZABETH SPALDING

St Ebba's Hospital,
Epsom, Surrey KT19 8QJ

Advertising chenodeoxycholic acid

SIR,—“Chendol can remove gall stones without surgery. Chendol solubilises 80% of all gall stones. Results of recent studies have demonstrated a 93% success rate in the United Kingdom for solubilising cholesterol-rich radiolucent gall stones in suitable patients.”

So runs the advertising copy for chenodeoxycholic acid (CDCA), accompanied by 10 oral cholecystograms, of which eight show radiolucent stones. Yet closer study of the reference quoted¹ reveals a very different story. One hundred and sixteen patients with a functioning gall bladder and lucent stones (that is, those suitable for CDCA) were entered in the trial. Forty patients managed to complete a year of therapy, and in this subgroup there was a 65% complete success rate and a 93% “partial and complete” success rate. But 44 patients were withdrawn from the trial, and in 25 the bile remained lithogenic despite apparently adequate doses. If the entire group of patients is looked at then 22% achieved complete dissolution, 21.5% failed because CDCA was ineffective, and 38% failed because the treatment was withdrawn.

Furthermore, the advertisement states in small print that “laboratory monitoring should accompany treatment,” yet few readers may realise that duodenal intubation is advocated to check that biliary desaturation has occurred.² During the time taken for stones to dissolve the patient is still at risk of the complications of gall stones, and there is at least a theoretical hazard that the shrinking stones could more easily pass through the cystic duct to cause biliary cholic, acute cholecystitis, empyema, obstructive jaundice, and pancreatitis—though in fact none of these complications has been proved to be increased.

There is probably a place for Chendol in that tiny minority of patients who are “medically” unfit for surgery but physicians should be wary of accepting at face value the inflated and misleading claims for this drug. Patients who are merely reluctant to undergo surgery should not be allowed to pressure their general practitioners into prescribing a not-very-effective and expensive preparation.

ALAN CAMERON

Whipps Cross Hospital,
London E11

¹ Maton, P. M., *et al*, *Gut*, 1977, **18**, A976.

² Bell, G. D., *Prescribers' Journal*, 1979, **19**, 87.

*We sent a copy of this letter to Weddel Pharmaceuticals Limited, the manufacturers of Chendol, whose reply is printed below.—Ed, *BMJ*.

SIR,—I have read Mr Cameron's letter with interest, and would offer the following comments.

Firstly, I think that we must qualify his remarks on the “93% success rate.” The 40 patients who form the basis of this claim were those who met the following criteria: (1) They

had radiolucent stones of less than 15 mm diameter in radiologically functional gall bladders. (2) They received adequate dosage of chenodeoxycholic acid (CDCA) (>13 mg/kg/day) for not less than 12 months. (3) Their bile was demonstrably unsaturated by this regimen.

Secondly, it is important to summarise the comments of Maton and his colleagues¹ on the 44 patients who stopped CDCA therapy. Twenty-seven patients came to surgery; three had non-cholesterol stones; nine defaulted after less than a month's treatment; 14 discontinued after less than one year's treatment; seven had stones of over 15 mm; and seven took suboptimal dosage (<13 mg/kg/day). Another patient was taking clofibrate, which causes increased biliary cholesterol saturation. Two patients died of unrelated causes. Six patients developed “non-opacifying gall bladders” and four developed biliary colic, with or without pancreatitis. The last sentence in the section entitled “Withdrawal” states, “Thus few patients stopped treatment because of CDCA failure per se.”

At the time when this study was conducted the indications and limitations of CDCA were still being defined by numerous clinical trials, of which this was one of the most carefully documented and, indeed, one of the major contributions to our present understanding of CDCA therapy. We have stated the indications and contraindications for chenotherapy quite unambiguously since they have been established.

Thirdly, I would question Mr Cameron's interpretation of “laboratory monitoring” in relation to Bell's paper.² Duodenal intubation is not advocated by us as a routine procedure and I see no obvious advocacy of it in Bell's paper. One sentence in this reads, “Furthermore, since most doctors will not have the facilities to perform duodenal intubation studies [undoubtedly true—WLA] and thereby check that their patients' bile has really become desaturated with cholesterol, even lower overall success rates may be reported in practice.” It is questionable whether this could reasonably be interpreted, in a clinical—or any other—context, as advocacy of duodenal intubation. “Laboratory monitoring” is a somewhat loosely definable expression and we have, in recent changes of advertisement, suggested that laboratory monitoring should be at the clinician's discretion. In using these terms, we have changed the emphasis from the non-specific laboratory tests required by drug registration authorities prior to obtaining a product licence to those called for in the course of ordinary clinical management. Duodenal intubation is not part of the standard range of “laboratory monitoring” and, except for specialised indications which in the context of CDCA therapy are related to investigative biochemical pharmacology rather than to routine clinical assessment, the assessment of gall-stone dissolution must be based on radiological or ultrasonographic methods, supported by clinical evaluation.

Mr Cameron alludes in his final paragraph to that “tiny minority of patients who are ‘medically’ unfit for surgery.” Cholelithiasis—in Westernised societies—is epidemiologically associated with degenerative cardiovascular disease, and I would be interested to know how many different phrases might be used for the proportion of unfortunate cholelithiasis patients whose hypertensive or ischaemic heart disease or chronic airways obstruction renders them poor or unacceptable surgical risks. I would have favoured “substan-