case with the help of psychologists, neurologists, teachers, etc.

In order to provide an early effective service, the job of "looking after" a mentally handicapped child or adult must be removed from the auspices of the National Health Service and entrusted to each county special education department, which will run special schools with residential places for these children. Mentally handicapped adults require residential hostels along with "sheltered workshops" where they can earn a fair wage commensurate with their productive capacity. Thinking and behavioural disorders developing in these two groups of people should then be treated by a psychiatrist as with any other group. If such a patient cannot return to his residential hostel, then he or she will be taken into a psychiatric hospital for long-term or short-term treatment according to the medical necessity. His or her return to the original residential setting should remain a distinct possibility at all times.

I think the time has come to reconsider and reform the mental handicap service in this country to make it more productive (both in the clinical and in the monetary sense) and to minimise waste.

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Royal organs

SIR,—Your leading article "Renal transplantation in the 1980s" (23 February, p 503) points to the continuing difficulties in obtaining a satisfactory supply of cadaveric kidneys and the same presumably applies to other useful donor organs. I put forward a suggestion which, had it been taken up, might have improved matters.¹

During the past few centuries the British Royal Family have at times exercised a considerable influence on medical practice. Even if we leave aside such interesting antiquities as the royal touch, Queen Victoria made anaesthesia in childbirth respectable literally overnight, while Edward VII may have had a rather similar effect on the diagnosis of appendicitis.

If any member of the Royal Family were to carry a donor card and publicise the fact, might not this increase the willingness of the public to donate and of doctors to ask the right questions at the right time? Old taboos seem to disappear more quickly when they are broken by leaders of a society. There is also the point that if, through the Royal Warrant, the Royal Family endorse the products of tobacco companies, surely they can spare a little support for procedures which may sometimes be useful in treating tobacco-induced diseases.

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¹ Brewer C. *Gen Pract* 17 March 1978:31.

New scheme for organ donors

SIR,—You will know that the Medic Alert Foundation has recently launched a new scheme to enable members of the public who wish to be organ donors to wear a bracelet or necklet indicating this. We were interested to read your leading article (16 February, p 427) on the whole transplant problem, but

felt that a mention might have been made of the Medic Alert system as we believe that this, if widely supported, would greatly increase the harvest of organs for transplantation.

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Volkman's ischaemic contracture

SIR,—I would like to draw attention to one point which was made in your recent excellent leading article on Volkman's ischaemic contracture (16 February, p 430). Although it is certainly important to examine for nerve function in the early stages for diagnosis, it is irreversible damage to muscle, not nerve, which is the most important feature of ischaemia of any limb. Seddon¹ noted that the vulnerability of nerve is considerably less than that of muscle. It is the function of nerves that is rapidly affected by ischaemia, as was shown by Lewis *et al* in 1931.² Lundborg³ has clearly shown that the intraneural microcirculation recovers completely after six to eight hours of circulatory arrest. Muscle fibres show changes after as short a time as one hour,⁴ and after six to eight hours irreversible changes will occur.^{5, 6}

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¹ Seddon H. *Br Med J* 1964;ii:1587-92.

² Lundborg G. *Scand J Plast Reconstr Surg* 1970; suppl 6.

³ Lewis T, Pickering G, Rothschild P. *Heart* 1931;3; 16:1-31.

⁴ Patterson S, Klennerman L. *J Bone Jt Surg* 1971; 61B:178-83.

⁵ Nolan B, McQuillan WM. *Br J Surg* 1965;52: 559-65.

⁶ Sharp A. *Med J Aust* 1964;51:210-4.

Antibiotic treatment for gangrenous and perforated appendix

SIR,—Mr D J Pinto and Dr P J Sanderson (2 February, p 275) make recommendations for prevention of wound infection in patients with gangrenous appendix that are irrational and the recommendations for prevention of wound infection in patients with perforated appendix are inadequate.

Treatment with metronidazole for five days reduced wound infection in patients with gangrenous appendix to 4.5%. This rate is marginally lower than the wound infection rate in their patients with normal or inflamed appendix, whether untreated controls or treated with metronidazole perioperatively, in whom the wound infection rates were 7.7% and 5.2% respectively. As they accept these latter wound infection rates and advise no antibiotics for such patients, it is surely irrational, despite the title of their paper, to recommend additional antibiotics for the regimen in gangrenous appendix, in which a lower wound infection rate had been demonstrated.

In perforated appendix wound infection rates commonly exceed 50% and their recommendation of full-spectrum systemic antibiotics for five days is essential. However, it is surprising that the advantages of intraoperative antibiotic peritoneal and wound lavage^{1, 2} have been overlooked again,^{3, 4} and until this technique is widely applied I foresee little

reduction in the alarmingly high rate of wound infection in patients with perforated appendix.

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¹ Noon GP, Beall AC, Jordan GL, Riggs S, De Bakey ME. *Surgery* 1967;62:73-8.

² Stewart DJ, Matheson NA. *Br J Surg* 1978;65:54-6, 446.

³ Anonymous. *Br Med J* 1979;ii:691.

⁴ Stewart DJ. *Br Med J* 1979;ii:1364-5.

Antibiotics in appendicectomy

SIR,—The conclusions reached by Mr D J Pinto and Mr P J Sanderson in their interesting paper (2 February, p 275) bear further scrutiny and analysis. In keeping with the practice adopted in several recent studies,¹⁻³ metronidazole was given as a suppository one hour before surgery, so that peak blood levels would be reached at the time of contamination of the wound. Ampicillin, however, was given intramuscularly preoperatively after the appendix had been brought to the surface, and therefore after it would have impregnated the wound with bacteria in its passage to the exterior. Not only was ampicillin a non-starter on this count but it was also stuck with the unfair disadvantage of having to cope with twice as many perforated appendices (16 as against eight for metronidazole).

Having, however, analysed their data from this protocol the authors go on to recommend that if a gangrenous or perforated appendix is encountered metronidazole should be given intravenously during the operation, together with cephazolin, a chemotherapeutic regimen which bears no relation to that given to their patients.

Other forms of therapy^{4, 5} compare favourably with the wound infection rate of 16% in patients with perforated appendicitis receiving metronidazole in this trial and clearly an improvement on this figure must be shown in a controlled study before a new antibiotic regimen is recommended.

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¹ Willis AT, Ferguson IR, Jones PH, *et al*. *Br Med J* 1976;ii:318.

² Rodgers JD, Ross P, McNaught W, Gillespie G. *Br J Surg* 1979;66:425-7.

³ Salem RJ, Johnson J, Devitt P. *Br J Surg* 1979;66: 430-1.

⁴ Pollock AV, Evans M. *Br J Surg* 1977;64:322-5.

⁵ Pollock AV, Froome K, Evans M. *Br J Surg* 1978;65: 76-80.

SIR,—As a cost-conscious surgical senior registrar I spend my time trying to coax SHOs into doing fewer out-of-hours tests and using cheap drugs. Consequently I was concerned to find no reference to cost in the consultant surgicopathological advice from Northwick Park Hospital on antibiotic therapy in gangrenous appendicitis (2 February, p 275). Mr D J Pinto and Dr P J Sanderson recommend metronidazole 500 mg intravenously + cephazolin 1 g intramuscularly every eight hours for five days, but also say that metronidazole may be given by suppository.

A telephone call to our pharmacy confirms the following prices for metronidazole: one bottle 500 mg (intravenous)—£6.40; one suppository 500 mg (per rectum)—33p; two 200-mg tablets (oral)—15p. There is a twentyfold difference between the first two.

Although a single perioperative intravenous dose of metronidazole may be countenanced,

surely postoperative treatment in appendicitis should normally be by suppository until fluids are being taken, and then be oral.

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Accidental self-inoculation with veterinary vaccine

SIR,—Two instances have come to the Health and Safety Executive's notice of accidental self-inoculation in the finger tip by operators administering an oil-based fowl pest vaccine. Both cases were treated at the nearest hospital, where the need for surgery was not appreciated. One patient lost the terminal phalanx and the other has loss of tissue and tenderness of the finger tip.

These injuries resemble those caused by high-pressure paint gun injuries previously reported.¹⁻³ Booth¹ commented: "... the dangers of injuries from high-pressure paint guns are not widely known... all cases should be treated by an experienced surgeon as fairly extensive surgery may be needed."

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¹ Booth CM. *Br Med J* 1977;iii:1333-5.
² LeBlanc JV. *J Occup Med* 1977;19:276.
³ Morley R. *Br Med J* 1967;i:25-6.

Eating and ulcers

SIR,—Your leading article on eating and ulcers (26 January, p 205) seemed dated. It was worth reminding doctors of the lack of evidence for the efficacy of classical ulcer diets in healing or keeping healed gastric or duodenal ulcers. However, the topical controversy is not whether a sloppy diet helps: it is whether the opposite regimen, a high-fibre diet, should be advised.

There has been one randomised controlled trial, in Bombay by Malhotra,¹ in 42 patients whose duodenal ulcers were healed and in remission. After five years 17 of 21 continuing on their staple rice diet had relapsed, compared with three of 21 changed to an unrefined wheat diet and told to chew each mouthful more than 60 times. This unrefined, masticatory diet was thick chapattis cooked with ghee, thick dhal, vegetable curries, and yoghurt. Would this regimen work in the West?

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¹ Malhotra SL. *Postgrad Med J* 1978;54:6-9.

* * Dr J H Baron, Professor J Yudkin, and Mr F I Tovey and others (16 February, p 483) rightly remind us that many types of diet—high-fibre and low-carbohydrate among others—may influence the course of peptic ulceration, and possibly diet is a major causative factor. The studies they mention are all of interest, therefore, but hardly provide "convincingly emphatic answers about the effects of diet," to the absence of which our leading article drew attention. Perhaps Dr Baron will be able, in due course, to tell us whether a regimen of "thick chapattis, thick dhal, vegetable curries, and yoghurt," or even

just unprocessed bran, will work in the West; but we doubt whether it is any more likely than milk and steamed fish to survive as a day-to-day therapeutic measure in the face of pharmacological progress.—Ed, *BMJ*.

In defence of "cranks"

SIR,—In his reply (9 February, p 401) to your leader on elimination diets in childhood (19 January, p 138), Professor J F Soothill rightly criticises the blinkered scepticism of the medical establishment when it is confronted with the converging body of evidence which implicates food intolerance, on whatever basis, as a cause of many types of disorder; and he aptly points out that editorial negativism in important places may prevent potentially valuable treatments from being made available to those who need them. Yet until such time as a sufferer from food intolerance can count on having the nature of his problem recognised by those officially responsible for his care and on obtaining effective relief from his suffering through official channels—a state of affairs that seems unfortunately a long way off—Professor Soothill's global denunciation as "quacks and cranks" of those unorthodox practitioners to whom such misunderstood and long-suffering people are, as he notes, forced to turn seems equally likely to deprive them of sources of relief. By their own account such relief is sometimes more effective than anything establishment medicine has been able to offer.

For the past six months I have been conducting a nationwide postal questionnaire survey of the experience of people with food and chemical sensitivities. The returns are not yet all in, but preliminary inspection of the data suggests that the final results will provide empirical support for the proposition that people would rather get reasonably well on "unscientific" grounds than continue to suffer their symptoms, drug side effects, fruitless investigations, and the stigma of being regarded as "difficult," "hypochochondriacal," or whatever on "scientific" ones.

If the work of the many "unorthodox" practitioners who are applying ideas that have gained widespread acceptance in the American literature could be given the same unbiased hearing as Professor Soothill would ask the establishment to grant to orthodox studies, the unproductive heat that this retrograde debate goes on generating might finally be replaced by a ray of much-needed light.

Meanwhile, the lack of official recognition and dissemination of knowledge about food intolerance among the medical profession does not prevent people from suffering its effects and succeeds only in reducing the credibility of doctors. As probably the only researcher in the country who is systematically studying the secondary handicaps arising from this widespread and often debilitating chronic condition, I find it a sad comment on orthodoxy that so many of my respondents, when asked if there were any particular worries which their special need to avoid certain foods in order to remain well caused them, mentioned the prospect of having to go into hospital for any reason. They anticipated that not only would their dietary restrictions not be respected but that they would also be regarded as "cranks" themselves. Such people are likely to avoid seeking treatment for other, accepted, conditions, for which orthodox

help is readily available. The iatrogenic potential, both positive (for example, physical and psychological harm inflicted) and negative (for example, beneficial treatment withheld), of medical dogmatism in this area is enormous and it is to the credit of patients' intelligence that they can see so much more than is dreamt of in doctors' philosophies.

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Heart disease, exercise, and life style

SIR,—I do not think that your reviewer JRH can be a running doctor or he would have been kinder to Dr Risteárd Mulcahy's book *Beat Heart Disease* in the "Positive Health Guide" series (23 February, p 557). As a GP who has been running since before it was respectable to do so, I find it a splendid book to recommend to my patients. It deals well with all the risk factors but the emphasis is on regular exercise, particularly walking, jogging, and running.

I find that if a person gets enthusiastic about these activities he will be motivated to alter his life style to enable him to jog or run better; this includes altering his eating habits, losing weight, and cutting down his smoking, so reducing more risk factors. This seems to me to be a much more positive way to reduce the risk factors than by doing it because of the fear of an untimely end.

I wish this little book every success.

JOHN COLE

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Exercise training in chronic bronchitis

SIR,—Your contributors Drs D J M Sinclair and C G Ingram (23 February, p 519) are to be congratulated on their study of the usefulness of exercise training extending over 12 months. The positive result is most encouraging and should lead to more bronchitic patients being helped in this way.

Nevertheless, in an issue when you, Sir, disclose that you use as a selection criterion for submitted articles that any treatment should be evaluated in a formal controlled trial it is disappointing that the control group was neither selected by random allocation of subjects nor given the same weekly visit by a nurse. The preferential reduction in smoking, symptoms, and hospital admissions among the treated group could have been due to this cause. Fortunately the main conclusion is not in doubt and has recently been confirmed in a study in which the formal conditions were fulfilled.¹ There is now a need for a similar study to evaluate the role of the respiratory nurse, whose help may itself be of great value to these patients.

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¹ Cockcroft A, Saunders MJ, Berry G. *Thorax* (in press).

SIR,—I was pleased to see a report of the evaluation of a simple exercise regimen in a chronic condition (23 February, p 519) but