indoctrination is allocated—if at all—by a computer for peripheral distribution.

In medicine, whatever may or may not apply to other disciplines, small is beautiful and best. It is also cost effective. The teaching and practice of medicine is a true vocation, best carried out on an individual basis or in small groups. Lord Flowers does not appreciate this. One example is his recommendation that the Institute of Basic Medical Sciences should be expelled from the University of London. He never visited the institute, never took evidence from it, never examined its finances, and apparently had no knowledge of its outstanding record. Did he arrive at his conclusions about the Westminster Hospital in the same way? His policy seems to be to destroy what he does not understand. Unless my ears deceived me the following pearls fell from his lips during his complacent justification of his report on TV: "Everyone wants to cultivate his own backgarden" and "They all have their tribal loyalties." Such superficial judgments have no place when dealing with the complexities of medical education.

It is too late to nip Flowers in the bud, but there is still time to ensure that he does not bring forth Dead Sea fruit.

MICHAEL REILLY

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SIR,—It is time someone was honest enough to stop pussyfooting about and admit quite straightforwardly that the Flowers Working Party's eruption suggesting that the Westminster Medical School should close is a concept of pure, unadulterated vandalism.

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SIR,—To use the heat bringing water to 100°C I just cover an egg with cold water and allow gentle boiling for 3½ minutes. So I disagree with Dr S K Mukerjee about eggs (15 March, p 798) but, oddly, agree absolutely with his sound principle that the aim is the best usage. Any institution in the community which is good may be monitored but should be supported and encouraged, *never* threatened, leave alone attacked. I am sure that there are many good area health authorities but it has been learnt that the upheaval which created them was unnecessary. We must stop repeating similar silly things.

Patients are people needing closeness and recognition. While special departments are essential, the more individual and identifiable treatment can be the better; more "familial" teams please, centred on sisters or charges and fewer faceless administrators from afar.

As one who has never studied in London, may I suggest that medicine, so often divided and conquered, unites on this issue and eliminates "reorganisationitis," whether caused by hard-boiled (by whatever method), uneconomical, penny-pinching politicians or by the wonderland of obsessive-compulsive DHSS?

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SIR,—I would like to comment on paragraph four of your leading article (8 March, p 665) "London's medicine." Apparently Lord Flowers's working party "took the advice of the University of London Medical Group

(representing medical students) that where a choice had to be made between close contact with their teaching hospital or education on the same site as other faculties students preferred the hospital contact—a decision that led to its verdict against King's College in the Strand and must have contributed to the verdict against the Westminster Medical School."

As an ex-Westminster student I did my preclinical studies at King's College in 1934 and greatly valued the contacts with students of all faculties, often made through the numerous college societies. I believe that this was also the experience of those who did their preclinical years at Oxford and Cambridge before going on to the Westminster.

Our profession can become very isolated from the rest of society and I am sure that this is made worse if students are cocooned in an exclusively medical environment from the time of leaving school at 18. To understand properly those we treat, as doctors, requires as good an education as possible among our contemporaries of all university faculties. I believe that this has contributed greatly to the success of the Westminster Medical School and its graduates in all branches of the profession.

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Outpatient follow-up after curative surgery for carcinoma of the large bowel

SIR,—The recent study by Mr John P S Cochrane and others (1 March, p 593) suggests a major change in the manner of outpatient follow-up after curative surgery for carcinoma of the large bowel. This is an important subject but the conclusions from their retrospective data are nihilistic and cannot pass unchallenged.

They suggest that symptomatic recurrence can be detected equally well by adequately educated patients as by a doctor. This may seem a reasonable idea but it overlooks the difficulties involved in teaching patients the significance of symptoms. Some individuals would minimise their complaints and not present until the late stages of recurrence and others would appear frequently in the clinic with trivial problems. The authors give no practical advice in this respect. However, the main questions at issue are whether asymptomatic recurrence can be detected by regular surveillance and whether this is of benefit to the patient.

Routine clinical examination and radiology will detect a group of patients with a metachronous tumour or suture-line recurrence in whom further surgery may be undertaken.¹ This alone may justify careful follow-up since a second resection may be curative. The additional use of tumour markers will increase the number of asymptomatic recurrences which are detected. In a prospective trial of 663 patients we have found a preceding rise in serum carcinoembryonic antigen (CEA) in 67% of 171 patients who developed a recurrence, the median lead time being 30 weeks (paper in preparation).

Is this warning of recurrence of any clinical benefit to the patient? Martin *et al* suggested second-look laparotomy when the CEA rose significantly above the patient's postoperative baseline.² To date this group has reported 60 such operations; 39% of the patients remain well, the longest disease-free interval being

in excess of seven years.³ However, the experience of other groups adopting a similar procedure has not been so encouraging,^{4,5} since we have found that a rise in CEA is more likely to accompany disseminated recurrence. The early introduction of systemic cytotoxic therapy has theoretical advantages,⁶ and we have shown a significant fourfold increase in the disease-free interval in patients in whom the CEA falls when therapy with fluorouracil and lomustine (CCNU) is introduced on the sole basis of a progressive rise in CEA. Thus this may be another small group of patients who benefit from the detection of asymptomatic recurrence.

It is our opinion, therefore, that regular follow-up after radical resection of colorectal cancer should be undertaken for three reasons: (1) Asymptomatic metachronous tumours and suture-line recurrences may be detected and further curative surgery attempted. (2) The serial assay of CEA will predict recurrence in the majority of patients and allow consideration of second-look laparotomy or cytotoxic therapy, which have been shown to improve the prognosis in some patients. (3) If regular follow-up is abandoned, surgeons will be left entirely ignorant of the long-term results of their operations. This may hinder future improvements in management.

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¹ Heald RJ, Lockhart-Mummery HE. *Br J Surg* 1972; **59**:16-9.

² Martin EW, James KK, Hurtubise PE, Catalano P, Minton JP. *Cancer* 1977;**39**:440-6.

³ Martin EW, Cooperman M, Carey LC. *VIIth Meeting of International Society for Oncodevelopmental Biology and Medicine*, 1979, abstract No 43.

⁴ Staab HJ, Anderer A, Stumpf E, Fischer R. *J Surg Oncol* 1978;**10**:273-82.

⁵ Cohen AM, Wood WC. *Surg Gynecol Obstet* 1979; **149**:22-6.

⁶ Sugarbaker PH, Skarin AT, Zamcheck N. *J Surg Oncol* 1976;**8**:523-37.

Second-best prostatectomy?

SIR,—It is sad that the trade union approach to demarcation has become entrenched in our profession. Your leading article "Second-best prostatectomy" (1 March, p 590) starts off with a very reasoned argument in favour of transurethral resection for the majority of benign enlarged prostates, explaining that many patients in hospitals where there are no specialist urologists do not have the chance of this excellent modern operation. The demarcation attitude, however, is exemplified by the statement that transurethral techniques can be learned only by "protracted apprenticeship and specialisation in urological surgery." To learn the technique of transurethral resection of a benign enlarged prostate apprenticeship by a well-motivated surgeon in training need not be protracted. Contact with urological surgery on a full-time basis for 18 months would equip a senior registrar in general surgery so that he could fulfil the role of a general surgeon with an interest and expertise in urology, which in your leader you say does not exist. Such a man practising both general surgery and straightforward urology in a district general hospital would be providing