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 back garden" 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

Yelverton, Devon

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.

E A HARVEY-SMITH

Purley Day Hospital,
Purley, Surrey CR2 4YB

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?

DAVID PARFITT

Bath BA2 2AX

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.

A S WATTS

Mortimer, Berks RG7 3SQ

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.

K R HINE

R GRACE

G D OATES
P W DYKES

Derbyshire Royal Infirmary,
Derby DE1 2QY

The Royal Hospital,
Wolverhampton WV2 1BT

The General Hospital,
Birmingham B4 6NH

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

the patients with an important service that is now not available, and by reason of his 18 months of urology he would be able to recognise more difficult conditions of the urinary tract, where referral of the patient to a specialist urological unit would be in the patient's best interest.

If we are going to be able to continue to provide a service to the community in the surgical specialties, such bridging of sub-divisions of surgery will be necessary. The closed-shop attitude of surgical specialties is to be deplored. I think that surgeons in training who wish to practise general surgery should spend between one and two years obtaining special expertise in other branches of surgery such as urology, vascular surgery, gastroenterology, and endoscopy, so that they can offer a higher standard of care in these subspecialties and still do their share of general surgical work. Such a simple and straightforward solution to unsatisfactory contemporary practice would require a change of attitude in those who espouse the doctrine of closed guilds.

ROY CALNE

University Department of Surgery
Addenbrooke's Hospital,
Cambridge CB2 2QQ

SIR,—Your leading article "Second-best prostatectomy?" (1 March, p 590) is the second such article in the *BMJ* in the last two years. On each occasion the case for the specialist urologist as an endoscopic prostatectomist has been advanced. Of course, in an ideal world all patients with prostatism or acute retention should be referred to a specialist urologist, as should patients with urinary tract infections, suspected ureteric colic, etc. Waiting lists for treatment would soon increase to such an extent that elective surgery would probably come to a standstill and treatment as an emergency become the order of the day. It is bad enough to wait six years for hip surgery but would it not be intolerable and often dangerous to wait such a time for prostatic surgery? I trust we are not returning to the era of the coiled catheter secreted within a black top hat?

Through miscalculation, or more probably the unfulfilled promise of finance for new urological posts, the urologists find an excess of highly trained young men with nowhere to go. There are many senior registrars in surgery who have an interest in urology but who do not wish to lose contact with the practicalities of general surgery. They could surely be more readily accommodated at a district general hospital than a specialist who feels uncomfortable about being on call for general emergencies yet is prepared to perform parathyroidectomies and anastomose the small bowel as a routine.

To say that the general surgeon with an interest in urology does not exist is as true as saying the urologist with an interest in general surgery does not exist. As your article points out, 80% of prostatectomies in England and Wales are performed by general surgeons. If the general surgeon with an interest in urology does not exist who, pray, is performing surgery on these patients?

If you had read my article "Prostatectomy at a district general hospital?"¹ you would have noted that the overall mortality was 14 in 600 (2.3%), 12 of the patients dying from cardio-respiratory disease—but in this group there was no significant difference in mortality between open operations and transurethral

resections. In case you select the 54-year-old man who died with mitral valve disease, actually he had a transurethral resection. Below the age of 70 (75% of patients) the mortality was 1%, from 70 to 80 years 2.2%, and over 80 (13% of patients) 7.4%.

There is a place for the specialist urological surgeon but it would be better for him to accept that the general surgeon with an interest in urology (who after all seems to do much of the work) does exist and can and should be taught to provide a safe and adequate service without relinquishing his interest in general surgery.

R D LEACH

Westminster Hospital Medical School,
London SW1P 2AP

¹ Leach RD. *Ann R Coll Surg Engl* 1979;61:459-62.

SIR,—Having just done a transurethral prostatectomy in which I resected 100 g of prostate tissue I was somewhat disturbed to read in your leading article (1 March, p 590) on prostatectomy that I do not exist. I was under the impression that I was a general surgeon with a special interest in urology.

Perhaps in an ideal world all urology would be done by urologists but we have to face the economic facts of life and I believe that the urological service provided by the general surgeon who devotes most of his time to urology is better than your article suggests. One will remember that the great names in urology in the recent past, in fact the founders of British urology, were general surgeons who later developed their interest in this specialty. A good urologist must be a good general surgeon capable of the surgery of the intestine, major blood vessels, adrenals, parathyroids, etc; while the general surgeon by building up the necessary experience can become a useful urologist, needing to refer only a small proportion of his work to a special unit.

R J LUCK

Datchet, Berks

Ingestion of household cleaning products

SIR,—For the period January 1974 to June 1975 calls about household cleaning agents received by the London centre of the National Poisons Information Service were retrospectively surveyed.¹ Of a total of 1457 cases, only a small proportion was followed-up in detail. Even so, the data were judged sufficient, along with other relevant published reports, to conclude that: (a) the intrinsic toxicity of most household cleaning products in the UK was not high; (b) there may be a risk of exaggerating the toxic hazards which household cleaning products present to the young; and (c) excessive medical treatment for cases of this kind should be abjured.

To check whether this state of affairs still prevailed three years later, another survey was carried out. This time it covered only three months, from November 1978 to February 1979. The total of cases was correspondingly reduced, being only 304 in all; but the adjusted annual rates were similar. To compensate for this relatively small sample, the effort was made to follow up each incident in depth. As it transpired, adequate follow-up was obtained for only 130 cases. The remaining 174 forms were not returned, which may or may not reflect their seriousness. Nevertheless,

a few probably valid generalisations can again be drawn. Once more, most of the inquiries originated from hospitals (90%) and most referred to children under 5 years of age (68%).

The distribution as between the various types of household cleaning products was very much as before, perhaps with the exception of "lavatory blocks," ingestion of which increased, although the overall numbers were small. It would be interesting to see if there is any relation here to sales over the period concerned. Once again the symptom picture was much the same as in 1974-5, with some two-thirds of the patients evincing no ill effects at all and the remainder suffering no more than nausea, vomiting, abdominal pain, and "burning" of the mouth. Everyone recovered satisfactorily and this time there were no deaths, though it will be remembered that the four deaths reported previously were all in adults who had deliberately swallowed excessive volumes of bleach.

Just as in 1974-5, in 1978-9 anything like major treatment was the exception and it is interesting to note the tendency for gastric aspiration and lavage to be performed less often still, no doubt because emptying the stomach in these circumstances has come to be judged of less importance and, in any event, for small children the policy has been firmly to recommend induced emesis instead.

Anyone interested in perusing the detailed tabulations is invited to write to us for a copy.

ROY GOULDING
PAMELA DURHAM
J N EDWARDS

National Poisons Information
Service,
New Cross Hospital,
London SE14 5ER

¹ Goulding R, Jenkins HL. *Br Med J* 1978;i:286-7.

Acute renal failure after a beer-drinking binge

SIR,—We were interested to read the report of two patients developing acute renal failure following excessive ingestion of ethanol (23 February, p 526). Dr R R Ghose and others propose that muscle damage and myoglobinuria led to the development of acute renal failure. However, in neither case is clinical or laboratory evidence provided to support this claim. We have recently seen a similar patient in whom there was clear evidence of acute muscle damage associated with myoglobinuria and hyperuricaemia.

A 32-year-old unemployed barman was admitted to hospital, having been found after lying overnight at home. For the previous two weeks he had drunk one to two bottles of rum a day. On examination he was unkempt and icteric with marked peripheral vasodilatation. His calves and buttocks were swollen, with extreme tenderness on palpation. He had evidence of mild Korsakow's psychosis and peripheral neuropathy. Blood pressure was 120/70 mm Hg. In the 12 hours following admission he passed only 50 ml of dark urine.

Blood urea was 33 n.mol/l (199 mg/100 ml) and he had a metabolic acidosis with bicarbonate 15 mmol (mEq)/l. Plasma bilirubin was elevated at 96 μ mol/l (5.6 mg/100 ml), aspartate transaminase 128 units/l. Urea-stable lactate dehydrogenase and serum creatine phosphokinase were grossly elevated at 354 and 827 units/l. Urate was grossly elevated at 1.76 mmol/l (29.6 mg/100 ml) (normal 0.12-0.42 mmol/l (2.02-7.06 mg/100 ml)). Both myoglobin and haemoglobin were detected in his urine; a haemolysis screen was negative. Following