other two patients had compound fractures and in both instances the brachial artery was severed. In each case the two ends of the artery were simply ligated and wound toilet was undertaken. In both instances the absence of a radial pulse is the only residual evidence of a vascular injury.

It appears, therefore, that Volkmann's ischaemic contracture may be the result of ill-advised bone manipulation when careful treatment of severe soft-tissue injury is the more urgent and important clinical problem. Dodge,² using a rather different clinical regimen, has similarly reported absence of ischaemic contracture in his series. Despite the persistent blame attached to supracondylar fracture for the highest numbers of contractures, our figures suggest that due care can eliminate the contracture from the scene.

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¹ Mubarak SJ, Carroll NC. *J Bone Joint Surg [Br]* 1979; **61B**:296-300.

² Dodge HS. *J Bone Joint Surg [Br]* 1972;**54A**:1408-18.

SIR,—I would like to amplify a point made by Mr Leslie Klenerman in his letter on Volkmann's ischaemic contracture (15 March, p 794).

In the experiments on laboratory animals referred to by Mr Klenerman Lundborg¹ showed that intraneural blood flow recovers completely after up to four hours' ischaemia; longer periods of ischaemia are followed by restoration of blood flow, but with increasing evidence of thrombus and embolus formation. Furthermore, when intraneural blood flow is restored oedema can be seen in the epineurial space after eight hours' ischaemia.

These findings emphasise the importance of early replant surgery following traumatic amputation.

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¹ Lundborg G. In: Daniel R, Terzis J, ed. *Reconstructive microsurgery*. Boston: Little, Brown and Co, 1977.

Abortion (Amendment) Bill

SIR,—The Guild of Catholic Doctors strongly deprecates the propaganda campaign which the British Medical Association launched against the recent Abortion (Amendment) Bill of Mr John Corrie, MP.

We accept that we live in a plural society and that the Association had been given a mandate by the 1978 Annual Representative Meeting to oppose any change in the 1967 Act. Nevertheless, since the Association claims to respect the conscientious views of all its members, we think it utterly wrong to have furthered this campaign, through the media and by letters to MPs, without giving any recognition to the fact that a substantial minority of members believes abortion to be morally wrong.

Such phrases as "The unanimous view of the medical experts" (2 February, p 269) fail conspicuously to acknowledge the point of view of those members who disagree. It is ironical that the same British Medical Association which opposed the 1967 Act at

the time should now describe itself to MPs as remaining "steadfast in its support for the existing 1967 Abortion Act."

We seek reassurance for our members and others that their conscientious views will not only be respected but will appear to be respected in the future.

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I JESSIMAN
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*.*The Secretary writes: "We hasten to reassure all those doctors who for ethical and religious reasons hold views contrary to those determined at the 1978 Annual Representative Meeting. In every field of medicine there is bound to be more than one point of view, and in correspondence—and indeed in quotations in the press—we have emphasised that our respect for minority opinions remains absolute. That respect, however, cannot alter our democratically determined policy."—ED, *BMJ*.

Pleural aspiration and biopsy

SIR,—May I rectify a serious omission in the recent article on pleural aspiration by Drs P B Iles and Colin Ogilvie (8 March, p 693)? Once the exploring needle has been advanced far enough to aspirate fluid it should be prevented from penetrating the chest further by clipping a strong artery forcep across its shaft flush with the skin.

Failure to take this simple precaution endangers the patient in several ways owing to the difficulty of keeping the needle immobile while manipulating a tap and syringe repeatedly, especially if the patient should cough or lurch back suddenly. As the needle moves between pleural space and skin the entry of bacteria and implantation of malignant cells is encouraged and, more seriously, penetration of a viscus is more likely with the needle free to move. The latter hazard is of particular importance when the diaphragm is elevated and is an anterior relation of the pleural space to a much higher level in the sitting patient than would be suspected from lateral radiographs taken during inspiration. I know of two cases where the diaphragm was known to have been penetrated; on one occasion the spleen was punctured and the patient became exsanguinated through bleeding into the left paracolic gutter; in the other case a pseudocyst of the pancreas was unknowingly tapped and leaked irritant fluid into the pleural space, causing considerable morbidity and diagnostic confusion.

Such complications can be prevented, and incidentally the maximum withdrawal of fluid can be achieved by immobilising the needle tip just within the pleural space in the manner described above.

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Evaluating urinary oestriol estimation

SIR,—Mr E J Shaxted's short report (8 March, p 684) concentrating on two out of 12 stillbirths in 1835 births is not really an adequate basis on which to assess the difficult question of the contribution urinary oestriol measure-

ment can make to reducing perinatal mortality. A recent survey of our own to be published elsewhere covered 626 perinatal deaths in 23 945 deliveries. No deaths attributable to chronic placental insufficiency were preceded by normal oestrogen values.

We agree with him that there is a world of difference between statistical and clinical significance; death knows no regard for two standard deviations from the mean. Predictions of risk can only be made in relation to information obtained when oestrogen concentrations have been found to be low, not acted upon, and the baby has died.¹

The arguments cannot all be expanded here but our experience leads us to the view that assaying 160 samples per week at a cost of about £0.90 per assay, equivalent to £2.00 per hospital delivery is money well spent.

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¹ Heys RF, Scott JS, Oakley RE, Stitch SR. *Lancet* 1968;**ii**:328-30.

Beta-blockers in immediate treatment of myocardial infarction

SIR,—In their excellently conducted trial of beta-blockers given early in suspected myocardial infarction (29 March, p 885), Dr R G Wilcox and his colleagues in Nottingham observed a mortality after six weeks of 8.1% in treated patients and 11.6% in controls. This difference was not statistically significant. They conclude that any difference which through chance they failed to detect "cannot be large enough to make a valuable contribution."

Clearly the authors, and perhaps many who read their conclusion, will now regard this particular question as closed. In fact, they observed a reduction in mortality of 30%; and their results are consistent, at the 95% confidence level, with a reduction of no less than 83%, or one life saved per 10 patients treated. Unfortunately in a study of this size a negative outcome proves nothing useful.

It is a pity, Sir, that editors do not follow the simple rule that authors should be required to report confidence limits in any negative trial. It might occasionally save a good treatment from premature dismissal.

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Indomethacin and perforated duodenal ulcer

SIR,—We have just read Mr M R Thompson's article on indomethacin and perforated ulcer (16 February, p 448). It seems to make an important mistake. Having noticed that a high proportion of women over 60 with perforated ulcer were indomethacin takers, the authors went on to compare their indomethacin consumption with that of a control group, who proved to have a lower indomethacin intake.

The author had no a priori reason to believe that indomethacin intake was especially frequent in women with perforated ulcer—he noticed an apparent oddity. To test if this meant anything he should have collected a

fresh group of ulcer patients and controls. To use an analogy, if I see three cars with registration plates which all bear registration numbers below (say) 10, I would not be sensible to test if this was an odd distribution by comparing with a matched control of the next three cars; yet this is what Mr Thompson seems to have done. His answer may be correct; his method of examination does not seem to be.

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Drugs for chronic diarrhoea

SIR,—The short report by Drs C D Shee and R E Pounder (23 February, p 524) confirms the widely held belief that one proprietary antidiarrhoeal preparation is much the same as another, but regrettably their study did not go far enough.

The first important question to be addressed is whether any of the preparations they investigated are effective at all. Their study showed that whatever drug regimen their patients followed they still had an average of 3.9 bowel actions a day, of which 72% or 73% were "loose." I do not agree that it would have been unethical to include a placebo in the trial. Two weeks of diarrhoea, while uncomfortable, is not likely to have any serious effect, particularly in this group of patients, and there would have been a high yield of useful information about the efficacy of the drugs under evaluation.

Secondly, it is a pity that the authors did not compare the effect of the "traditional" antidiarrhoeal drugs in their study with prostaglandin-synthetase-inhibiting drugs. There is good evidence¹⁻⁷ that many diarrhoeal states are mediated by excessive production of prostaglandins within the gut. A trial with simple aspirin or one of its analogues may be surprisingly effective in preventing chronic diarrhoea.

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¹ Cummings JH, Newman A, Misiewicz JT, Milton-Thompson GJ, Billings JA. *Nature* 1973;243:169-71.

² Gould SR. *Lancet* 1975;ii:988.

³ Mennie AT, Dalley VM, Dineen LC, Collier HOJ. *Lancet* 1975;ii:942-3.

⁴ Bennett A. *Adv Prostaglandin Thromboxane Res* 1976;2:547-55.

⁵ Robert A. *Adv Prostaglandin Thromboxane Res* 1976;2:507-20.

⁶ Buisseret PD, Youtlen LJF, Heinzelman D, Lessof MH. *Lancet* 1978;i:906-8.

⁷ Buisseret PD, Youtlen LJF, Heinzelman D, Lessof MH. *Monogr Allergy* 1979;14:197-202.

Investigating constipation

SIR,—Your leading article (8 March, p 669) mentioned a stricture complicating ulcerative colitis in a manner implying that such a stricture might well be benign. Two clinical dicta must be remembered in conjunction with that statement. A benign stricture in association with inflammatory bowel disease colitis nearly always means that the colitis is granulomatous and not ulcerative. A stricture in association with true ulcerative colitis is nearly always malignant and must be so regarded. Error in the former decreases

diagnostic accuracy; in the latter it may cost a patient his or her life.

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London's medicine

SIR,—The dermatologists working in the South-east Thames Regional Health Authority area are worried by the proposals in the Flowers report (8 March, p 731) on the relocation of the Institute of Dermatology and St John's Hospital for Skin Diseases, in a truncated form, at the new St George's Hospital, Tooting. They support strongly the letter of Dr R H Meara (29 March, p 936).

All of us, and this includes colleagues elsewhere in the Home Counties, lean heavily on the services offered by the institute and hospital. These include separate clinics specialising in the lymphomas, contact dermatitis, occupational dermatitis, leprosy, photo-dermatitis, and urticaria. St John's also has a large photochemotherapy department for patients with psoriasis; many district hospitals do not possess this facility.

While some form of rationalisation of both undergraduate and postgraduate centres is necessary and inevitable, some of the proposed changes seem to be irrational on both economic and demographic grounds, and will certainly—in our specialty—eliminate services which are not available elsewhere.

The journey from outlying areas of Sussex and Kent, and from the Greater London area to the centre of London, is one which most patients can reasonably undertake. Tooting and the site of the new St George's are relatively inaccessible. Likewise our junior medical staff with a heavy clinical commitment will be deterred from attending essential weekly seminars and lectures owing to the travelling time involved.

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Medical school intake and manpower implications

SIR,—The letter "Medical school intake and manpower implications" (22 March, p 859) by representatives of the collegiate members of three Royal Colleges of Physicians suggests that the intake to medical schools should be held static until a standing forum has been set up to provide continuing informed advice on medical manpower from student intake to retirement. This is a striking reversal of the sentiments that were widespread only a few years ago and that led to the conclusions and recommendations of such bodies as the Royal Commission on Medical Education to increase the output of medical graduates.¹

The high and rising prevalence of doctors in the past few years should not have come as a surprise. It could have been predicted. It has occurred in obedience to an epidemiological law—prevalence equals incidence multiplied by duration. The duration of doctors is about 40 years on average. The incidence, the number of new graduates each year, has increased greatly over the past 30 years. This is responsible for the profuse supply which is leading to a surplus. I have to confess rather ruefully that I did not identify explicitly the underlying epidemiological law in my publi-

cations on medical manpower, which began about 15 years ago²; but at least I can claim to have expressed scepticism about the recommendations of the Royal Commission on Medical Education regarding medical manpower.^{3,4} I wish I had been bolder; but then probably no one would have listened even if I had.

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¹ Royal Commission on Medical Education. *Report 1965-68*. London: HMSO, 1968.

² Last JM. *Med J Aust* 1964;ii:244-52.

³ Last JM. *Lancet* 1968;ii:166-7.

⁴ Last JM. *Br Med J* 1969;ii:769-72.

Protecting superabundant doctors

SIR,—It is widely believed that in the near future there will be a superabundance of doctors in Britain, and there are already signs that it is becoming less easy to find posts in general practice. Similar conditions prevailed 25 years ago, and at that time many stories of exploitation of young doctors were to be heard. The General Practice Reform Association was formed to try to combat such abuse as the assistantship with view in which the partnership never materialised, and partnerships that were offered on disadvantageous terms with long periods to parity. It was not very successful and was disbanded when the turn of events made its activities unnecessary.

It is our fear that although the structure of general practice today makes some of these abuses less likely other abuses may still be inflicted on too many young doctors competing for too few vacancies. Very shortly all entrants will need to have completed three years' vocational training and are all the more deserving of fair treatment and consideration by those of us who are established principals.

Is there any way in which a code of practice can be introduced which would perpetuate the present customs of a short period of mutual assessment followed by a reasonably generous starting share and not more than three years to parity?

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Clinical complaints

SIR,—Mr William Russell's article (22 March, p 877) on the failure of Jack Ashley's Bill to allow the Health Service Commissioner to investigate matters of clinical judgment does not tell the whole story and should not be allowed to give us the feeling that the problem and threat are now over.

The public, represented by certain politicians and the House of Commons Select Committee, are anxious to see complaints about clinical methods and judgment investigated fairly without the need to start an action for negligence. The Joint Consultants Committee came up with a solution (two independent consultants investigating and reporting to the local regional medical adviser), which I am afraid will simply not be enough to satisfy what occasionally are legitimate complaints. There is also the pressure for automatic no-fault compensation schemes in cases of "medical injury" where negligence is not an issue. We doctors in turn are be-