may be responsible for stress. Though this possibility should not be overlooked, simple observation of increased smoking during war time suggests that smoking alleviates stress or fulfils some other basic human need (for example, relieves boredom) for many people, a view consistent with the US Surgeon-General's recognition of "significant beneficial effects of smoking primarily in the area of mental health."³

Dr T Khosla and Professor H Campbell (2 February, p 331) suggested that, by restricting my attentions to those under 65, I had given a misleading picture of the effects of giving up smoking in all age ranges. Certainly, as they point out, deaths from smoking-associated disease are common in the old and deaths from stress-related disease rare; but they overlook the fact that the association of mortality with smoking, especially for heart disease, is much stronger in the young than the old.⁴ In any case, not only do a substantial proportion of older people give up smoking anyway⁵ but one's main concern is surely with prevention of early deaths.

Professor M R Alderson (12 January, p 108) quotes the conclusion of Fletcher and Doll⁶ that doctors who stopped smoking were in general aware more of benefits than of any sense of deprivation, either physical or physiological. Although such a result could be accredited to the "Hawthorne effect"⁷ (that is, a tendency to report what is expected) this may still be true. What is of interest is that a substantial number of doctors actually reported disadvantages from stopping. The point I was making was that giving up smoking may have adverse consequences to some people, not that it had adverse consequences on balance for everyone.

Professor Alderson also states that I suggested that male doctors' mortality trends declined in the period 1931-51. I did not—my whole paper was concerned with trends in mortality *relative* to those in control groups and not with trends in absolute mortality rates at all. Dr Joan M Davies and Clair Chilvers (9 February, p 400) in fact suggest that study of trends in absolute mortality rates might have been more appropriate. I avoided this because I felt it unreasonable to assume that cigarette smoking was the only exposure variable which had changed over the period 1951-71. I found their alternative "summary and conclusions" misleading, as it appeared too ready to attribute all the "savings" and none of the "losses" to giving up smoking when, as pointed out above, the story is by no means so simple.

Richard Peto (personal communication) points out that in the population as a whole smoking-associated diseases, in particular lung cancer and chronic bronchitis, are much more common than in doctors and stress-related diseases are much less common. Thus even if giving up smoking did act to increase deaths from stress-related disease this increased risk would for the average man be likely to be relatively small compared with his decreased risk from smoking-associated diseases.

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¹ Doll R, Peto R. *Br Med J* 1976;ii:1525-36.

² Friedman GD, et al. *J Chron Dis* 1979;32:175-90.

³ Advisory Committee to the Surgeon General of the Public Health Service. *Smoking and health*. Washington: US Department of Health, Education, and Welfare, 1964:356.

⁴ Townsend JL, Meade TW. *J Epidemiol Comm Hlth* 1979;33:243-7.

⁵ Lee PN. *Tobacco Research Council Research Paper No 1*, 7th ed. London: Tobacco Research Council, 1976.

⁶ Fletcher C, Doll R. *Br J Prev Soc Med* 1969;23:145-53.

⁷ Levine RJ, Cohen ED. *Clin Res* 1974;3:111-2.

SIR,—Dr T Khosla and Professor H Campbell (2 February, p 331) conclude that for the large majority of smokers it is prudent to give up the habit and that this is true for every subgroup of the population. This being so, it both puzzles and worries me that two particular groups show little sign of giving up (if my

observations hold true throughout the country)—namely, nurses and school teachers.

This is especially strange in the case of nurses as it is they who have to deal with the unpleasant end results of smoking in their patients. So far as teachers are concerned, I can well understand the stress which induces them to smoke during breaks and at lunch time. But what sort of example does it set to their pupils when smoke oozes out of the staff room and their clothing constantly reeks of stale tobacco? Perhaps the Health Education Council could turn its attention to these two groups in particular.

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Mitral valvotomy—value of the closed technique

SIR,—Following your recent leading article on mitral stenosis (12 January, p 63), we would like to plead for the continued use of closed valvotomy, notably in third world countries where large numbers of patients with mitral stenosis could overwhelm the relatively small number of surgical units equipped for open heart surgery. These units might be better treating conditions that can only be benefited by bypass operations.

Since 1956 at St Mary's closed valvotomies have numbered 501, with four deaths. Follow-up of those initially treated with the Tubbs dilator (374 patients) extends for over 15 years. Significant numbers have been examined for 10 years postoperatively, and show a consistent benefit symptomatically, 94% having only grade 0 or 1 residual disability. Reoperation (for up to 15 years) was required in only 19 patients. From our 14 years' experience in Malta, 57/100 000 of the population have required a closed valvotomy; extrapolation to India's population might therefore suggest 456 000 in need of valvotomy.

Open valvotomy is clearly impracticable for such numbers. Unfortunately the successful use of the Tubbs dilator depends on the skill and experience of the middle-aged and older cardiac surgeons, as the younger generation is trained in open techniques. The economy and speed of closed valvotomy, by contrast, makes it essential that younger cardiac surgeons are taught this expertise before their seniors retire or expire.

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How necessary are elimination diets in childhood?

SIR,—Your recent leading article on elimination diets (19 January, p 138) is a contribution to ignorance, written, it seems, without much clinical experience.

There is no doubt that many children and adults are intolerant of cows' milk. It would be surprising if they were not, considering that the stuff is designed for infant cows, not humans, and often contains antibiotic residues.

In my 20 years experience of using elimination diets,^{1 2} I have found milk to be the third commonest food implicated in food intolerance, after white flour and instant coffee. Any

mother whose child's intractable eczema has cleared with the elimination of cows' milk would agree that this dairy product should carry the same Government health warning as cigarettes.

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¹ Mackarness R. *Not all in the mind*. London: Pan Books, 1976.

² Mackarness R. *Chemical victims*. London: Pan Books, 1980.

Eating and ulcers

SIR,—In 1901 the Government was alarmed to find that up to 60% of men presenting themselves for recruitment for service in the South African war were unfit. In its alarm the Government consulted the Royal College of Surgeons and the Royal College of Physicians. Today, looking back, no one doubts that this unfitness amongst recruits derived from the diet of the poorer folk of those days but, at the time, the Royal Colleges held no such view. The director general of medical services, they said, had not made out a case for believing that any deterioration of physique had occurred.

It is disturbing to some of us to find that your leading article "Eating and ulcers" (26 January, p 205) is distinguished by your persistence in a parallel viewpoint. Old standpoints, we recognise, die hard. You commit the error about which all medical students are warned; you concentrate on the treatment of this disease while ignoring the cause. Had you for one moment considered the aetiology and epidemiology of ulcer you could not have entered a plea that patients with, or liable to, duodenal ulcer should be given the opportunity to "eat injudiciously without risk." The phrase "eat injudiciously" should, however, be noted. Epidemiological studies throughout the world show a correlation between a high ulcer incidence with national diets high in refined carbohydrates and poor in nutrients. In the 1920s and 1930s Sir Robert McCarrison showed that the diets of native races in India which produced a high ulcer incidence in those populations were of this kind; such diets also produced a high ulcer incidence in laboratory rats.

It is not possible in a letter to do more than utter a cry of pain at the resolution with which editors who pronounce on medical affairs turn away from evidence of a causal relation between diet and health. In the best medical tradition they are content if, at a later stage, the profession is from time to time successful in treating ill health.

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Services for the mentally handicapped

SIR,—Dr N S Gordon (9 February, p 403) rightly questions the viability of a medical specialty of "mental handicap," but to my knowledge no consultant appointments have been under this description for some considerable time. There are, of course, quite a number of consultants (usually whole-time) in the psychiatry of mental handicap. They reflect Dr Gordon's own recommendation that there should be "some specialisation within the rubric of psychiatry." They may at times find themselves involved in other disciplines, and in administration; but this is often, as with