primary iron storage disease studied here this patient did demonstrate a very slow-moving iron-binding compound on polyacrylamide gels after incubation with ^{59}Fe .

(3) Our choice of the word "abnormal" was unwise as we meant to indicate that the tumour ferritin was different from hepatic ferritin rather than implying a demonstrated functional abnormality. Unfortunately, further studies could not be carried out on this patient but the presence of the tumour ferritin and secondary siderosis (histologically) seemed to warrant the speculation.

ROBERT BATEY

Medical Unit,
Royal Free Hospital,
London NW3

Hepatitis B and endoscopy

SIR,—We were interested to read the recent paper by Dr D B L McClelland and others reporting the absence of transmission of hepatitis B by gastrointestinal endoscopy (7 January, p 23). We would like to report a similar episode which occurred in our unit in November 1974.

A 51-year-old man was admitted as an emergency with melaena. There was no preceding history of jaundice and on examination no stigmata of chronic liver disease were found. Endoscopy showed large oesophageal varices and these were identified as the source of the bleeding. A hepatitis B antigen (HBAG) assay was therefore performed and found to be positive, but owing to failure of communication this did not become known to the endoscopy team until February 1975. As at that time the endoscope was cleaned with Savlon only it was decided to screen all patients endoscoped within three weeks of the incident. These 28 patients were seen between the 81st and 97th day after their endoscopy. Clinical examination revealed no evidence of either acute or chronic liver disease and liver function tests were normal. Immunoelectrophoresis and turkey erythrocyte haemagglutination tests for HBAG and immunoelectro-osmophoresis tests for antibody to HBAG (anti-HB) were negative in all patients, who were then followed up for the full incubation period of 160 days, no case of jaundice occurring.

We therefore concluded that the risk of transmitting HBAG via a contaminated endoscope must be small. To minimise this the endoscope is now soaked in glutaraldehyde for 20 min at the end of each endoscopy list.

A G MORGAN
W A F MCADAM

Endoscopy Unit,
Airedale General Hospital,
Keighley, W Yorks

B E WALKER

Chapel Allerton Hospital,
Leeds, W Yorks

Autoclavable Forrester laryngeal spray

SIR,—I am grateful to Drs M W Casewell and M T Dalton (10 September, p 680) for drawing attention to the possibility of cross-infection when using the Forrester laryngeal spray. I have been in touch with Penlon Ltd, the makers of the redesigned spray, and they have reassured me that this spray is fully autoclavable. An extract from their letter reads as follows:

"The current version of the Forrester spray which has been produced for the past five years is entirely autoclavable, provided the bulb is removed. The metal components are all stainless steel, the now very limited lengths of flexible tubing have

been autoclavable silicone since the production commenced, and the bottle and lid are made of TPX, which is a fully autoclavable plastic. TPX does tend to lose transparency with repeated autoclaving because of water absorption, but it is not distorted at the normal 136°C autoclaving temperature.

"It is of course absolutely essential to ensure that the spray is clean before autoclaving in order to prevent blockage of the fine internal passages. These can be cleaned by filling the spray bottle with water, preferably warm, and operating the spray until the bottle is empty."

I feel, therefore, that the improvements suggested by Drs Casewell and Dalton have been adequately catered for for some considerable time, and I hope that this assurance should allay any disquiet resulting from their communication.

ALEX C FORRESTER

Glasgow

Silk sutures in the common bile duct

SIR,—The report by Mr B I Rees and Mr G Jacob (12 November, p 1265) made the very important point that silk should not be used to ligate the cystic duct because such ligatures may find their way into the main ductal system to become the nuclei of stones or to be associated with other problems. We have recently seen a patient with both a silk ligature in the lower reaches of the common bile duct and a difficult stricture of the upper common hepatic duct and the confluence.

Cholecystectomy for stones within the gall bladder was performed in February 1976 (JMA). There had been no jaundice and there was no evidence of ductal stone or inflammation at operation. Operative cholangiography through the cystic duct was performed without difficulty; no stones or other abnormalities were seen. Since there were no operative difficulties and there was no obvious contamination of the operative site with bile, antibiotic was not given. The bile was not cultured. In the postoperative phase there was more upper abdominal discomfort than expected and some pyrexia. This settled and the patient was discharged after two weeks. There was no wound infection. Subsequently the patient had occasional episodes of upper abdominal discomfort and in September 1977 he developed jaundice. A percutaneous transhepatic cholangiogram showed a stricture at the uppermost part of the common bile duct. At operation (LHB) on 20 December 1977 induration and old granulation tissue was found around the upper part of the common bile duct at the site of the stricture. The filling defects in the lower part of the common bile duct consisted of some debris and a portion of knotted black silk, clearly the ligature previously used to occlude the cystic duct. Repair of the stricture was technically difficult as a result of biliary cirrhosis, small intrahepatic ducts, and an abnormal anatomical relationship between the portal vein and the hepatic ducts. Right hepatic lobectomy with anastomosis of the left hepatic duct to a Roux loop was performed.

It seems that a postoperative abscess might have formed alongside the common hepatic duct associated with stricture formation and the passage of the silk ligature into the ductal system. This experience confirms the view that problems can arise from the use of non-absorbent materials around the biliary ductal system and that silk ligatures may pass into the bile ducts postoperatively.

JOHN MAXWELL ANDERSON
L H BLUMGART

University Department of Surgery,
Royal Infirmary,
Glasgow

Lung cancer risk in pipe and cigar smokers

SIR,—I was pleased to see the recent article by Dr J A McM Turner and others (26 November, p 1387) about cigar and pipe smokers inhaling and cancer risks. There have been many articles implying that all pipe and cigar smokers are relatively free of the high cancer risk which cigarette smokers have. The article by Dr Turner and his colleagues supports earlier work indicating that many pipe/cigar smokers do inhale,¹⁻³ but it still does not confirm that pipe/cigar smokers who inhale actually have an increased risk of developing lung cancer similar to cigarette smokers. There has been some suggestion in the literature that the relative safety of pipe/cigar smoking may be related to different methods of curing the tobacco or different leaves used rather than inhaling.⁴ On the other hand there has been comment that pipe or cigar smokers who inhale may actually have a risk of developing cancer greater than cigarette smokers.⁵⁻⁷

What is needed to answer this question is a good (ideally prospective) study of the cancer risks in pipe/cigar smokers who do and who do not inhale. This would be an extremely important and timely research, as many of the people who have given up smoking cigarettes in the past few years have taken up smoking cigars and pipes because of the alleged reduced risks of lung cancer and other diseases and it is this very group who are most likely to inhale.

STANLEY P BOHRER

University of Rochester
Medical Center,
Rochester, New York

¹ Castleden, C M, and Cole, P V, *Lancet*, 1973, **2**, 21.
² Cowie, J, Sillett, R W, and Ball, K P, *Lancet*, 1973, **1**, 1033.

³ Goodman, A L, *Chest*, 1977, **72**, 33.

⁴ Passey, R D, et al, *British Medical Journal*, 1971, **4**, 198.

⁵ *British Medical Journal*, 1973, **2**, 172.

⁶ Goodman, A L, *American Review of Respiratory Diseases*, 1976, **113**, 87.

⁷ Armitage, A K, et al, *British Journal of Pharmacology*, 1977, **59**, 439P.

Smoking behaviour in medical students

SIR,—I would like to add something to the letter from Dr I C McManus and his colleagues (21 January, p 175). It is not only the medical students at Cambridge who smoke less than expected: the habit is generally regarded by the student community as unacceptable. I would suggest that social reasons are responsible: if five people smoke simultaneously in the typical small college room inhabited by most Cambridge students the atmosphere rapidly becomes intolerable.

The fact that the medical freshmen reported in the McManus study smoke less than their non-medical peers may be that they are trying to conform to the idealised stereotype of the clean-living medical student. The example of the medical teaching staff soon shatters this illusion.

Another factor driving students to cigarette smoking is the work load. All medical courses are understandably hard work. However, it would appear that Cambridge is beginning to place demands on its medical students which they cannot meet. This has led to something of the order of 30% of second-year preclinical students failing to gain exemption for qualifying examinations in some subjects. At present we are not only producing another generation of

heavy-smoking doctors to continue setting a "good example" to the community but also cohorts of graduates who will want the content of medical courses radically changed. This may not be in the profession's best interest.

CHARLES CLAOUÉ

Churchill College,
Cambridge

The cancer patient: communication and morale

SIR,—We note with warmth and interest Dr T B Brewin's article (24-31 December, p 1623) and the subsequent correspondence (21 January, p 178) on this desperately important topic.

During last autumn we interviewed a small series of patients with carcinomatosis and, where relevant, their spouses as a project for the general practice part of the clinical curriculum. Our findings were then discussed in a small seminar with other students and doctors.

Our patients gave evidence that confirmed our previous impression that full and frank discussion of the diagnosis with both patient and spouse at the same time was eventually warmly appreciated by both sides and facilitated discussion and possibly the effectiveness of symptomatic treatment. Requests for prognosis should be resisted: one patient was still alive and mobile for two years after an outlook of less than three months had been given.

Opinion at the subsequent seminar was that the patient's right to know what is wrong should usually override the doctor's very doubtful ability to tell whether the patient is intelligent enough or emotionally strong enough to receive the news.

J ROSSITER
Medical student
PETER MOFFITT
General practitioner

Bristol

Cimetidine in "chickenpox oesophagitis"

SIR,—I recently had the misfortune to have chickenpox. On the fourth day my general misery was exceeded only by fairly severe retroxiphisternal pain, worsened by lying down. The next day I developed some heartburn; the pain moved higher up and was increased by eating and drinking hot fluids.

At this point my cowardice overcame the spirit of scientific inquiry and instead of undergoing endoscopy to confirm a presumed diagnosis of oesophageal involvement by chickenpox vesicles I put myself on cimetidine 1 g daily. The effect was rapid and by the next day I had no pain. Four days later, by which time I had numerous vesicles in my mouth and a sore throat, I stopped the drug. The pain soon returned but disappeared quickly after restarting treatment. A further four days later I was finally able to stop the drug and had no recurrence of the retroxiphisternal pain.

Though I was unable to find any supporting published literature despite computer assistance, it seems quite likely that the oesophagus can be involved by chickenpox and that it was the cause of my pain. The oesophagus, like the skin, is lined by squamous epithelium

and might therefore be affected by varicella. Another virus, herpes simplex, which typically produces skin vesicles, can also affect the gullet,¹ and my colleagues in general practice and in infectious diseases hospitals tell me that they have not infrequently encountered retroxiphisternal pain in this illness.

Cimetidine is known to be effective in reflux oesophagitis²; I presume I had transient reflux, possibly due to sphincter dysfunction following infection. However, I am unaware of a report on its use in "chickenpox oesophagitis." Perhaps other readers may have come across this condition and have treated it. I would welcome their comments.

K D BARDHAN

Rotherham Hospital,
Rotherham, S Yorks

¹ Steisenger, M H, and Fordtran, J S, *Gastrointestinal Disease*. Philadelphia, Saunders, 1973.

² Burland, W L, and Simkins, M A, *Cimetidine: Proceedings of the Second International Symposium on Histamine-H₂-Receptor Antagonists*. Amsterdam, Excerpta Medica, 1977.

Henry VIII and the NHS

SIR,—Mr M J Gilkes in his Personal View (14 January, p 103) makes some interesting comparisons between the present state of the Health Service and the monasteries at the time of their dissolution. I think I can answer some of his queries.

In the north at least local people rebelled strongly against these changes. The revolt known as the Pilgrimage of Grace resulted from the dissolution of the smaller monasteries in the north—for example, Sawley. The leaders of this rebellion controlled almost the whole of the north of England and had a greatly superior military strength when they confronted the royal forces at Doncaster. King Henry escaped by agreeing to the rebels' terms and made promises which he never intended to keep. Like other politicians he was more concerned with not being shown to have broken his word than actually keeping it, and the herald who conveyed his promises to the rebels was later executed on a trumped-up charge of treason, a salutary lesson for our negotiators today, who should also remember that this unsuccessful revolt destroyed any hope of preserving the best of the monastic system.

There is no evidence that bribery or co-operation with the establishment saved any of the monasteries, though it might have increased the pensions of some of the "retiring" abbots. Nor did excellent service in the past seem to help; the reason why Ely was saved and Tintern destroyed was that in one case the public at large had a right to use the church and in the other they had not. An excellent example can be seen at Bolton Priory, where the nave alone remains today as a parish church with a solid stone east wall, while the chancel and the rest of the priory are in ruins.

The lesson here is that our services to the general public *today*, and not in the past alone, will count.

J S H LODGE

Wetherby, W Yorks

Conciser, but is it nicer?

SIR,—Miss Jane Smith, in her admirable account of subediting problems (28 January, p 222), stresses the need for "conciseness."

Might not "concision" be conciser—and nicer?

PATRICK TREVOR-ROPER

London NW1

*Miss Smith replies: "Conciser, yes, but not necessarily nicer. According to the dictionary the primary meaning of concision is 'mutilation' or 'circumcision,' which is not at all what I wanted to suggest."—ED, *BMJ*.

More health education needed

SIR,—During the 30 years of the NHS frequent criticism has been directed at doctors, administrators, and other health workers in their efforts to make the service viable.

Intensive antenatal care, early detection of fetal abnormalities, postnatal examination of babies, efficient immunisation, and medical examination of children have all helped to produce a healthier younger generation. Screening procedures have helped in the early detection of disease. Pathological and radiological services have aided diagnosis and modern drugs properly used have produced great advantages in treatment.

The doctors and their helpers have done well for the Health Service despite the politicians, but what of the patients? There is disinclination to breast-feed; instead grandma or any other willing helper is left to feed and often overfeed with artificial mixtures while mum goes to work. Schoolchildren return to empty houses, bribed with pocket money which is spent on sweets and fish-and-chips, so starting faulty eating habits. Obesity, smoking, and lack of exercise tend to be corrected only when the first coronary episode has been survived. Painful deformed feet from ill-fitting shoes afflict many women. Lower limb joints ache under the strain of too big a load.

I have mentioned only a few of the self-inflicted disabilities, but if only patients took advice as readily as tablets there would be much less cause for criticism of the service. Unfortunately doctors represent only thousands of votes compared with patients' millions, but informed health education could convert the National Disease Service to the National Health Service.

LEWIS D RUTTER

Leiston, Suffolk

Devolution and the Health Service

SIR,—It is disappointing to read about the controversy surrounding the Scotland Bill on devolution and the alleged effect this may have on abortion availability. Does the BMA really oppose the Scottish Assembly having control of the Health Service in Scotland?

I am a member of the Scottish Council of the BMA and I would not support any attempt to divide up the administration of the service after devolution. I am not in favour of any more devolution at all; I believe it is economically and politically wrong and in the very short-term financial interest of Scotland, only because of the few years that we shall have North Sea oil.

But if we are to have devolution let's have it properly; the Health Service is already suffering from too much administration; attempts to devolve some and not all of it would only add to the difficulties. There will