lung surface were frequently inspected during the procedure of pleural adhesion section by cautery, used to permit free lung deflation during artificial pneumothorax for pulmonary tuberculosis. Thus as a young consultant physician working in a thoracic surgical unit one had ample opportunity to inspect the visceral pleura and to note differing appearances. Because of this facility with the thoracoscope we took the opportunity of inspecting the pleura during chemical pleurodesis for recurrent "idiopathic" spontaneous pneumothorax. We recognised, as does your leading article (11 December, p 1407), that this condition is most common in tall "lanky" young men, but we observed in addition that these patients have a specially thin, transparent visceral pleura studded with dozens or even hundreds of surface blebs. We had no doubt that each of these represented herniation of a group of alveolar sacs covered by paper-thin pleura. It seemed clear to us that any one of these minute hernial blisters might burst spontaneously and that the degree of lung deflation would be proportionate to the size of the resultant puncture hole.

Why tall, thin young men have a thin pleura is open to conjecture, but your observation that spontaneous pneumothorax is found in Marfan's syndrome may be relevant.

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Retinal vein occlusion

SIR,—I was interested in the up-to-date approach to this subject in your leading article (11 December, p 1406). You correctly infer (without mentioning by name) that this is a "stasis" retinopathy in which complete thrombosis of the venous lumen is unusual and in which visual recovery is more related to retinal capillary damage than to the extent of haemorrhage.

However, under management you have failed to mention the value of an intravenous plasma volume expander such as dextran 70, which is useful in states of capillary anoxia and which may have a dramatic effect when given within the first 24 h of visual loss.

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Timing of cervical smears

SIR,—I am pleased that the DHSS has at last made some effort at clarification of the payment of fees to general practitioners for cervical smears, but as one who has had some experience in gynaecology it gives me much distress that an attempt is still being made to discourage smears at any greater frequency than five years. This is particularly anomalous when I think back to the 24-year-old whom I saw die of carcinoma of the cervix and to the many young women under 35, and of low parity, in whom I have diagnosed carcinoma-in-situ or invasive carcinoma by the use of frequent smears. Indeed, it is policy at the hospital where I work as clinical assistant and at the family planning clinics I do to repeat all routine smears at 18 months' interval.

This policy of the DHSS is therefore designed to encourage me to have a double

standard according to whether I work in my practice or not. Naturally I will not drop my standards and will continue to take smears at 18 months' interval and be paid for about one in four. Many other practitioners will of course not adopt this policy, and in spite of statistics on the occurrence of carcinoma-in-situ I wonder whether this is in the best interests of the health of the country?

Would it not be possible to pay for all smears which a GP considers worth taking, thereby doing away with one clerk whose job must be to vet the claim forms submitted? Surely no GP is going to take smears at ludicrously frequent intervals just to get a fee of £2.30?

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Integrated approach to asthma

SIR,—It is ironic that in the same issue of the *BMJ* as *Integrated Medicine: The Human Approach* is so favourably reviewed (4 December, p 1394) there should be published a letter from Dr H W Fladée (p 1383) criticising you for publishing an article which emphasises the importance of such an approach in childhood asthma (23 October, p 1003).

Dr Fladée suggests that social circumstances are irrelevant in asthma and thus "all the talk about the family is so much verbiage." The influence of sociopathology in childhood asthma has been very clearly demonstrated by Pinkerton,¹ while there have been two recent comprehensive reviews of all the evidence for the significance of social factors.^{2,3} Evidence is now also available demonstrating the effectiveness of a combined medical and psychosocial approach to the problem.⁴

To dismiss so forcibly social aspects as verbiage reveals, at very best, an unfortunate ignorance of the literature on the subject.

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¹ Pinkerton, P, *Psychotherapy and Psychosomatics*, 1970, **18**, 231.

² Mattson, A, *Pediatric Clinics of North America*, 1975, **22**, 77.

³ Pilling, D, *The Child with Asthma*. Slough, NFER Publishing Co, 1975.

⁴ Liebman, R, Minuchin, S, and Baker, L, *American Journal of Psychiatry*, 1974, **131**, 535.

Management of appendicitis

SIR,—Mr A W Clark (9 October, p 881) reports that of 28 patients with a gangrenous or perforated appendix, 18 developed post-operative infections whether antibiotics were used or not. His suggestion that delayed primary suture of the wound will reduce sepsis rates in those cases with a high risk of post-operative infection is intriguing. If, as he suggests, the wound is closed at four days the patient may need a second anaesthetic, discharge from hospital will certainly be delayed, and the final scar may well be unsightly. Fraser-Moodie¹ carried out a trial of delayed primary suture in six patients with suppurative appendicitis and reported that five of these patients developed severe wound infections which took from one to three months to heal.

Mr Clark's letter makes one suspect that few surgeons at King's College Hospital accept

that the most important pathogen in the genesis of infection after appendicectomy is *Bacteroides fragilis*. These anaerobic organisms are not sensitive to the antibiotics most frequently used for patients with a gangrenous or perforated appendix—namely, penicillin and streptomycin,² ampicillin,³ and penicillin and gentamicin.⁴

Leigh⁵ and Willis⁶ have demonstrated a marked fall in sepsis rates when appropriate antibiotics such as lincomycin and metronidazole are used. At this hospital we have recently conducted two trials using metronidazole alone for the prevention of sepsis after appendicectomy.^{6,7} In these two trials there were 27 patients whose appendix was gangrenous or perforated and in these patients there were six infections. These infections were minor or superficial and no patient received further chemotherapy. This group of 27 patients, all admitted with severe intraperitoneal infection, stayed in hospital between three and 15 (mean 6.7) days.

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¹ Fraser-Moodie, A, *Journal of the Royal College of Surgeons of Edinburgh*, 1974, **19**, 121.

² Longland, C J, et al, *British Journal of Surgery*, 1971, **58**, 117.

³ Leigh, D A, *British Journal of Surgery*, 1975, **62**, 375.

⁴ Lari, J, et al, *British Journal of Surgery*, 1976, **63**, 643.

⁵ Leigh, D A, *Journal of Clinical Pathology*, 1974, **27**, 997.

⁶ Willis, A T, et al, *British Medical Journal*, 1976, **1**, 318.

⁷ To be published.

Hip fractures up to date?

SIR,—In his article concerning current practice in the management of patients with hip fractures (11 December, p 1429) Mr P A Ring states correctly that pulmonary embolism is the commonest postoperative complication. In fact, approximately one patient out of every 10 will die from pulmonary embolism within three months of injury unless an effective prophylactic measure is adopted.^{1,2} However, he states that "an elastic supporting stocking to encourage venous return, early mobilisation, and keeping the legs horizontal when sitting are probably as important as any of the medical measures of prophylaxis." This viewpoint is indefensible, for there is no evidence that such simple physical measures can protect these high-risk patients from pulmonary embolism.

Moreover, with the exception of anticoagulation there is no clearcut evidence that any of the currently available prophylactic methods are of value in elderly patients with fractures of the femoral neck. Unfortunately, Mr Ring is correct when he states that prophylactic oral anticoagulation has not gained wide acceptance. According to our survey³ only 3% of orthopaedic surgeons routinely use this measure in patients with hip fractures despite the weight of evidence favouring its use.^{1,2} We accept that prophylactic anticoagulation is tedious and not without complications, but it will prevent pulmonary embolism.

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¹ Sevitt, S, and Gallagher, N G, *Lancet*, 1959, **2**, 981.

² Morris, G K, and Mitchell, J R A, *Lancet*, 1976, **2**, 869.

³ Morris, G K, and Mitchell, J R A, *Lancet*, 1976, **2**, 867.