receptor content to equal extent but has a larger effect on rapidly proliferating cells than on slowly growing cells.⁵ Recent data show that receptor-negative human breast cancers generally have a higher growth rate, as indicated by a higher labelling index and mitotic index.⁶ The conclusions by Lipmann *et al* may therefore have to be amplified to state that human breast cancers with low oestrogen receptor content usually are the more rapidly growing tumours and consequently are relatively more sensitive to cytostatic treatment.

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Prevalence of multiple sclerosis in north-east Scotland

SIR,—We note with interest the comments of Dr A J Silman (2 September, p 703) concerning our assertion that the prevalence of multiple sclerosis in north-east Scotland shows a significant deviation from random distribution (29 July, p 314). We were not aware of any marked variation in the age distribution in the area and further statistical analysis of the 20-50-year age groups supports this. A subsequent study in 1973 (yet to be published) reveals a higher overall prevalence and higher rates for 22 out of the 28 districts. Many of the additional patients should have been included in the 1970 study but were missed at that time.

We would disagree with the second comment that the prevalence tended to increase nearer to Aberdeen. The map of the relative prevalence shows, for instance, that all Banffshire districts were above the mean despite the fact, as mentioned in the paper, that there might be a slight loss of patients from such peripheral areas to adjacent regions. The ease of access to Aberdeen therefore does not seem to be a factor, and in fact no part of the area is difficult of access except for short periods in the winter.

We would agree with the final comment that further studies of HLA status of patients in a high-risk region would be valuable and hope that such studies can be pursued locally.

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Bacterial colonisation of small intestine in tropical malabsorption

SIR,—We enjoyed the paper by Professor G C Cook (22 July, p 238) and suggest that his demonstration of delayed small-intestinal transit in severe cases of tropical malabsorption, confirming earlier impressions from barium studies in southern India,¹ is of considerable importance. However, we do not

consider that the bacterial colonisation commonly present in such cases with² and without³ giardiasis is necessarily the result of abnormality of intestinal transit because we have shown that bacterial colonisation, albeit in lower numbers, also occurs in patients with mild tropical malabsorption without steatorrhoea⁴; such patients would have normal intestinal transit by Professor Cook's criteria. The aerobic flora of both our severe and mild cases, predominantly *Klebsiella pneumoniae*, is different from the anaerobic flora of patients with intestinal stasis.⁵

The finding of bacterial colonisation in patients with acute gastroenteritis and the demonstration that such organisms possess colonisation factors⁶ suggests that it may be characteristics of the bacteria rather than a change in intestinal transit which determine colonisation. Nevertheless, it is still far from clear which is the primary event in many intestinal diseases of the tropics and further studies are needed.

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Nasogastric suction in acute pancreatitis

SIR,—I am sure that Dr R Naeije and his colleagues (2 September, p 659) are correct in their conclusion that nasogastric suction is unnecessary for most patients with mild or moderately severe pancreatitis, a conclusion which is probably applicable to the majority of the therapeutic advances made towards such patients.

Acute pancreatitis is a very variable condition and I feel that caution is needed before applying the results of a clinical study of this type to the routine management of the condition. A randomised study of 58 patients is perhaps rather lacking in numbers for any trend to appear when a fairly mild spectrum of disease is studied in a fairly young group of patients. Death has traditionally been the most useful end-point to use in the assessment of treatment for this disease, and in this study no patient died. It is well recognised that the clinical assessment of an attack of acute pancreatitis can be most misleading and patients with severe disease can appear to be quite mildly ill on first acquaintance. Furthermore, observations of the effect of acute pancreatitis in experimental animals indicate how common dilatation of the stomach can be, and this is also a feature of attacks in man, especially in the elderly.

While I would agree that the omission of this rather unpleasant form of treatment does not often influence the outcome of an attack, I think that it is very difficult to pick out the minority of patients in whom it is likely to be of benefit in a prospective manner. Thus we would omit nasogastric suction from routine management only in young, fit patients who appear to have very mild attacks of pancreatitis. The remainder have a nasogastric tube which

is withdrawn as soon as abdominal pain subsides (so long as aspirates are not high). In many patients the tube remains in situ for only a few hours.

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Toilet paper and spread of infection

SIR,—An important change in community hygiene has taken place in recent years with the introduction and increasing use of soft toilet paper. At first some people found the soft paper difficult to use owing to its porosity and lack of strength, but most were soon able to use it satisfactorily. Its superior cleansing power was demonstrated to me some years ago when I planned a long-term study of intestinal infection in a large children's home using soft paper in alternate cottages. The study had to be abandoned because the reduction in soiling of underclothing in the cottages using soft paper was so striking that the staff in the other cottages could not be persuaded to persist with the old paper.

In an intestinal infection spread largely by personal contact, such as Sonne dysentery, contamination of the clothing and of the skin of the perineum and buttocks can act as a source of continual infection of the hands, from where infection can pass to other persons. Soft toilet paper was introduced soon after the last war, but its great increase in popularity took place in the period 1957-71. Today the amount of hard paper in use is comparatively very small indeed. From 1957 onwards notifications of dysentery in England and Wales declined steadily. In the period 1957-9 the average annual notifications were 34 214. In the years 1969-71 the figure was 14 524 and in 1975-7 only 6776.

The mere fact that a reduction in dysentery and the introduction of soft paper were related in time does not, of course, prove that one is the cause of the other. The reduction in dysentery probably has a complex origin, arising from a number of different causes. It seems reasonable, however, to believe that the increased use of soft toilet paper may have been one factor in the decline.

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Hospital inquiries

SIR,—I was interested to read Dr D A Spencer's letter on hospital inquiries (16 September, p 828). I feel very strongly about the way in which the medical profession tends to be casual about the predicament in which some of our colleagues may find themselves as a consequence of such "inquiries." After one particularly well-publicised and extensively reported inquiry south of the Border the consultant concerned was publicly crucified by the chairman of the health board and the matter was given headline coverage in many national dailies. What was never adequately emphasised was that this man was doing the work of three consultants with poor junior staff and was indeed dying during this inquiry. I tried very hard to stimulate some interest in the profession at the time so that the grossly unfair verdict and the publicity received by this unfortunate consultant could be countered by the profession, but to little or no avail. The