study. Similar high figures have been found for the whole South Western region (2.64/1000 in 1987; data provided by the regional information unit). The reason for the high incidence of the syndrome in Avon is unclear but may in part be due to the fact that equivocal findings are less likely to be recorded as a cause of death. If government recommendations to establish a paediatric pathologist in each region are implemented the difference between the incidence in Avon and elsewhere may diminish.

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Dyspepsia in general practice

SIR,—As a radiologist who performs both endoscopy and double contrast (or, more properly, multiphasic) barium meal examinations I wish to take issue with Drs W D W Rees and C M Brown with respect to their reply to correspondence relating to their editorial on diagnosis in patients with dyspepsia.¹ They accuse Drs M A Sampson and C Record² of being “misguided and emotive” in their response and state that “their comments are mostly irrelevant” and “form a highly biased appraisal of the relative merits of endoscopy and double contrast barium meal examination.” They themselves seem to be guilty of virtually all these faults.

They state that “to suggest that double contrast barium meal examination can approach the diagnostic accuracy of gastroscopy with biopsy and cytology is totally unacceptable” but fail to give any evidence backing up this charge. I suggest that the reason for this is that sound evidence is actually lacking. There have been very few well controlled trials (the best being by Dooley *et al*³) that have shown this advantage. Most published work on the relative merits of these two examinations is plagued by the bias which is again shown in their reply.

Though I suspect that endoscopy does have a slightly higher accuracy than barium meal examination, I don't think that this has, in fact, been proved and has to be weighed against the definite, albeit low, morbidity (around 0.1%) and mortality (around 0.04%) associated with endoscopy.⁴ Also, endoscopy undoubtedly misses lesions (in one study 13% of gastric ulcers seen on barium meal examination were missed on initial endoscopy⁵) and therefore cannot be considered the gold standard implied in their editorial and subsequent correspondence.

The evidence that modern radiological examination of the upper gastrointestinal tract is comparable in accuracy with endoscopy has

recently been reviewed⁶ and is also supported by evidence from Japan.⁷ Simpkins has pointed out that if all 400 000 patients who undergo barium meal examination in England and Wales each year underwent endoscopy instead about 33 deaths would result.⁸ I wonder how many lives would actually be saved.

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*This correspondence is now closed.—Ed, *BMJ*.

Attitudes to chemotherapy

SIR,—Dr M L Slevin and colleagues showed that patients with cancer regard treatment and the resulting morbidity differently from people in good health.¹ Nowhere is this difference more evident than in surgery for cancer of the head and neck, as a review of 965 patients treated at Hull Royal Infirmary (1962-86) confirms.

Logically, it should be patients who have had head and neck surgery with its attendant functional and cosmetic defects who should question its use, particularly if additional surgery is required. Of 651 patients who received definitive surgery, 136 had a recurrent tumour and were offered further surgery; 47 of them had a second recurrence and were offered more surgery. (In total 201 operations were offered to 136 patients.) Of those who had had surgery, only four refused a second or additional operations. In the series as a whole 13 patients refused all treatment and another 17 refused surgery but accepted other treatment.

Patients find radical treatment acceptable if it offers the best prospect of cure.

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- 1 Slevin ML, Stubbs L, Plant HJ, *et al*. Attitudes to chemotherapy: comparing views of patients with cancer with those of doctors, nurses, and general public. *Br Med J* 1990;300:1458-60. (2 June.)

Report from the LMC conference

SIR,—I wish to correct what I think is a misleading report on our debate on minor surgery at the conference of representatives of local medical committees.¹

In particular, I did not report that the ligation of varicose veins had been removed from the list of minor surgery procedures but said that this proposal was a part of a package of proposals from the Department of Health to change the regulations in the future to prevent general practitioners remaining on the minor surgery list

unless they can show competence in all the listed procedures.

In addition, in supporting the motion from Bedfordshire that all minor surgery should stop in the event of the government insisting on general practitioners being competent in all the listed procedures I explained in my opening address the steps we have been taking to try to resolve this dispute with the Department of Health. I outlined the efforts that had been made to obtain a meeting with departmental officials, reported their failure to explain the reasons for adopting their present stance on the question of “competence,” and emphasised the extent to which the General Medical Services Committee and its negotiating team shared the frustration felt by the profession.

None of this was included in the report published in the journal, and this is particularly regrettable because an inference could be wrongly drawn that there was some difference of view and emphasis between the committee and the conference. In fact there is none: the committee is just as incensed and concerned about this matter as the conference showed it was in the resolution it carried.

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- 1 Beecham L. GPs foresee battle for resources in the '90s. *Br Med J* 1990;300:1657-60. (23 June.)

Creutzfeldt-Jakob disease

SIR,—Mr G Gasser highlights the lack of up to date guidance on sterilisation and disinfection procedures relating to handling patients suspected of having Creutzfeldt-Jacob disease.¹ I suggest that guidelines should be very similar to the recommendations from the committee report from the American Neurological Association on Creutzfeldt-Jacob disease.²

The report states that steam autoclaving at 121°C for one hour or 132°C for 15-30 minutes and then the use of 1N sodium hydroxide for 15 minutes or at a lower concentration for one hour is only partially effective. Similarly, immersion of instruments in bleach (up to 1 in 10 dilution) for one hour does not produce full protection. Bernouilli *et al* have reported putative transmissions through the use of in depth silver electrodes despite attempts to sterilise them in 70% solution of alcohol and formalin.³ It is well known that ethanol, usol, iodine and alcohol solution, and ultraviolet irradiation are totally ineffective at sterilisation.

The American report recommends that full protection is afforded by steam autoclaving for one hour at 132°C and then immersion of instruments in 1N sodium hydroxide for one hour at room temperature.

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- 1 Gasser G. Creutzfeldt-Jacob disease. *Br Med J* 1990;300:1532. (9 June.)
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Correction

Creutzfeldt-Jacob disease

An editorial error occurred in this letter by Mr G Gasser (9 June, p 1523). The use of 1N sodium hydroxide is recommended for sterilising material and not isotonic sodium hydroxide as published.