of an acute episode of abdominal pain and presented the findings at the meeting of the British Paediatric Association in 1975. Briefly, we found that the 235 admissions with acute abdominal pain accounted for 9.4% of non-waiting-list admissions in that 12-month period. Thirty-one admissions were for chronic or recurrent pain and 204 for acute pain. A breakdown of diagnoses followed the same general pattern as found by Mr Jones and was as follows:

Unexplained	36%
Appendicitis	28%
Upper respiratory infection (including 7 cases of influenza B)	11%
Constipation with soiling or urinary retention	3%
Gastroenteritis	3%
Urinary infection	3%
Mesenteric adenitis	3%
Major psychological problems	3%
Pneumonia on chest x-ray	2%
Miscellaneous (including 5 admissions with duodenal ulcer pain)	8%

Laparotomy was performed in 78 instances and in only five was no abnormality found. Seven of eight children aged between 3 and 6 years with appendicitis had peritonitis or abscess formation at the time of laparotomy and only 37.5% of these were in hospital within 48 h from the onset of pain compared with 83% of children aged 9-12 years. Overall, for children with appendicitis there was a significant difference in the delay before admission to hospital between the uncomplicated and the complicated cases. Reasons for delay were not always recorded, but in five of the 14 instances in which delay extended into the third day the family doctor had not been called. In another five instances the family doctor had visited before the third day but thought that the pain was non-surgical in origin and did not arrange admission.

Thus 10 years after Jackson's paper we found continuing evidence of the same delays. Further improvement in the morbidity and mortality of acute appendicitis will come only when parents are educated to call the family doctor if any abdominal pain in a child lasts eight hours or more and family doctors refer the young patient with abdominal pain to hospital earlier than at present.

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¹ Jackson, R H, *British Medical Journal*, 1963, 2, 277.

Closure of dirty and untidy wounds

SIR,—It is always reassuring to see fundamental principles of surgery being restated as in your leading article on this subject (11 September, p 600). I would suggest, however, that those of us who instruct undergraduates and junior doctors in the management of dirty and untidy wounds in accident and emergency departments are in a very strong position to inculcate these basic principles at the beginning of their training. There are many so-called minor wounds (such as animal or human tooth wounds and flap avulsion wounds of the shin in middle-aged or elderly ladies) which are best treated by adequate primary excision followed by delayed primary closure, as indicated in your leading article. This can often be carried out as an outpatient procedure.

Good habits instilled thus early in training are likely to be carried over into the more major injuries which a doctor will be meeting later in his professional life.

Finally, application of these principles to such minor wounds must surely result in a greater total saving of disability in the community than results from the proper treatment of the much less common, but more serious, wounds which require inpatient treatment.

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Medical newspeak

SIR,—I wonder if many of your readers are subjected to this latest craze. I know psychologists often have a varied and difficult professional task. Nevertheless, is the jargon in this copy of part of a letter from a psychologist to her psychiatrist about a patient of mine really helpful?

(1) Ventilation of sexual material with the view to a reduction in her tremendous sense of guilt and worthlessness.

(2) Deflection of her present involvements into more satisfactory and acceptable people of both sexes.

(3) Lessening of her social phobias by planned outings, etc.

(4) Exploration of the family situation and assistance in separating herself from them, aiming towards moving out of home eventually.

(5) Exploration of the possibilities for improvement in her work situation, through help toward accepting more responsibility leading towards promotion or a change of job.

I cannot print my partner's interpretation of the first undertaking. Though somewhat cryptic, could we not have had:

(1) Talk sex to gain confidence.

(2) Select friends.

(3) Go out.

(4) Leave home. (In fact this would have solved the lot.)

(5) Change job.

J LAURENT

Chorleywood,
Herts

Teaching of anatomy

SIR,—As your leading article (11 September, p 603) rightly suggests, the teaching of anatomy to the undergraduate and to the surgical trainee are not separate issues. Poor pay, inferior status, and the continuing rigid boundaries between preclinical and clinical departments have led to a dearth of medically qualified teachers in anatomy. This can result only in anatomy teaching which is research and not clinically relevant, confirming the opinions of those misguided medical educators who see no reason for any anatomy teaching at all.

The solution is in the form of the anatomy demonstratorship for surgical trainees. This fulfils two needs. The first is for clinically relevant topographical anatomy teaching which is economical in its consumption of curriculum time. In Bristol the demonstrators prepare dissections before teaching and as a result students spend only 160 hours in the dissecting room in their two preclinical years. The second need is for a basic anatomical grounding for the surgical trainee. In no other situation can the aspiring surgeon enjoy open access to dissection material and this unique opportunity to learn anatomy. I would urge that at least six months in an anatomy demonstratorship be included in the long-term surgical training programmes which are now evolving

in many centres, for the benefit of the future of surgery and the quality of undergraduate anatomy teaching.

Continuing education in anatomy for the surgeon goes hand in hand with increasing operative experience; this could be supplemented by the use of audiovisual aids, such as film loops on the anatomy of a specific area, or even the provision of a prepared cadaver as in some residency programmes in the United States. After all, some of our most eminent surgical forefathers spent an hour in the dissecting room before tackling a particularly challenging case.

NEIL MORTENSEN

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Management of appendicitis

SIR,—The complications of appendicectomy continue at an unnecessarily high rate, possibly because the facts available in the literature have not been combined in a single clear statement.

I recently carried out a retrospective survey of wound infection in 140 consecutive appendicectomies in the King's College Hospital Group with particular reference to the antibiotic-using habits of the surgeons (all senior registrars or registrars with FRCS) supervising or performing the operation and the state of the appendix at operation. If we exclude those who did less than five operations or who were totally consistent in their use or non-use of antibiotics there remain 94 operations performed by discriminating surgeons. When the appendix was described as infected or inflamed by both surgeon and histologist they used antibiotics 15 times, with two subsequent wound infections, and refrained 42 times, with 11 infections. This is the same advantage of 1:2 found in the prospective study of Gilmore and Martin¹ and so confirms the notion that there is no way of judging when to use an antibiotic in these circumstances. When the word "pus" or "gangrene" appeared they used antibiotics four times and refrained 13 times, with a total of eight wound infections. When the word "perforation" was used 10 out of 11 gave antibiotics, with nine infections, while the eleventh patient, without an antibiotic, suffered both a wound infection and a pelvic abscess.

I believe there is now sufficient information on which to make rational choices in managing this disorder, based on the appearances at operation:

(1) If the appendix is normal or inflamed a topical antibiotic or povidone-iodine will decrease the chance of wound infection by half or more (roughly, from 20% to 10%).¹ Systemic antibiotic treatment will very probably eliminate the chance of intraperitoneal complications at all stages of the disease but will have to be given to 40 patients in this group unnecessarily for each successful prevention.²

(2) If the appendix is gangrenous the chance of wound infection increases to 50% or more, the most effective local agent is probably povidone-iodine, and the chance of intraperitoneal complications rises to about 12%, making systemic antibiotic treatment more worth while.²

(3) If the appendix is perforated the chance of wound infection rises to 80% and of intraperitoneal complications to 40%. Clearly systemic antibiotics are indicated, with a wider spectrum than metronidazole alone, but neither systemic nor topical antibiotic treatment improves the wound infection rate,^{1 2} and rubber drains are valueless.²

May I suggest that we cease to suture the

wound primarily in perforated appendicitis and possibly in purulent and gangrenous cases too. (When else would one sew up tissues steeped in faecal pus?) An acceptable alternative is delayed primary suture, with a wet gauze pack to the intermuscular layers for four days.

I am grateful to my colleagues who kindly allowed me to examine their patients' records, so illustrating the need for another look at appendicectomy.

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¹ Gilmore, O J A, and Martin, T D M, *British Journal of Surgery*, 1974, **61**, 281.

² Magarey, C J, et al, *Lancet*, 1971, **2**, 179.

School pregnancies

SIR,—Caroline Woodroffe suggests (18 September, p 694) that multiple youth advisory clinics on the lines of "the Brook" should be set up by the NHS. She apparently expects doctors to accept under-16 sexual intercourse as the norm and that we should therefore provide girls under that age with both contraception and abortion.

Do the Brook Advisory Centres produce any publicity to warn young adolescents of the health hazards (physical and emotional) of early sexual intercourse (for example, cervical disease) and the positive benefits of restraint? Do they help parents, teachers, and youth workers to understand the considerable health risks and emotional stresses from sexual pressures on this immature age group? We know after all that delinquency and precocious sexual activity are closely associated. The only "Brook" literature I have seen was entitled "Safe Sex," which is apparently the current euphemism for contraception and abortion.

As doctors we need to scrutinise much more closely the "brain-washing" of adolescents by the media, including teenage magazines, and some of our own profession. It sometimes appears as though "sex" is the current exploitation by some adults of the immature young, rather as though it was intended as a drug. Can we wonder at the consequences in terms of misery and distress to schoolchildren and their parents? Who is really benefiting?

ELIZABETH ELLIOTT

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Early diagnosis of breast cancer

SIR,—Dr Gisela Gästrin from Finland reports a more efficient method of self-examination in the early diagnosis of breast cancer (25 September, p 745). As a result 76 of 62 000 women were found to have breast cancer and she states that there was no exaggerated fear of cancer among the participants.

Experience in Britain shows a very different picture. The majority of women with breast lumps whom I see are absolutely terrified of cancer. Why is this so? It is because they fear they may lose a breast and die from the disease. If treatment were highly effective the public would soon reflect the optimism few of us have at the moment. The late Sir John Bruce¹ put the position well: "For, sadly, few of us today approach the treatment of breast cancer with any real confidence in what we have to offer."

Further, Baum² stated that most cases of breast cancer seen in practice must be considered incurable and cites evidence that a tumour 1 cm in diameter originated 2-8 years before clinical presentation.

Until our treatment of breast cancer improves we owe a duty to the public to stop advertising the "importance" of early diagnosis of this disease. Those who fear that such a policy would lead to an increased incidence of "late" cases can rest assured. Our misguided propaganda has so terrified the public that it will be 20 years before this is likely to happen and by then treatment may be more effective.

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¹ Bruce, J, *Journal of the Royal College of Surgeons of Edinburgh*, 1975, **20**, 287.

² Baum, M, *British Medical Journal*, 1976, **1**, 439.

Successful treatment of choking

SIR,—I have been asked by my colleagues to report on a boy of six whom I saw on 20 November 1975 dying of asphyxia and on whom I tried a new first aid manoeuvre from the U.S.A.¹

I was called to a school two minutes from my house and found this boy unconscious and cyanosed. Since I was told he had been choking I assumed someone would have already banged him on the back. Before embarking on a tracheostomy I tried the new first aid method, which consists basically of sharply pushing the upper abdomen upwards.

Immediately he coughed, brought up half a green pea, and recovered consciousness. In hospital later no further foreign bodies were found and he has gradually recovered from a collapse of his right lower lobe.

While in hospital he remembered that a month before, while playing with a pea-shooter, he had sucked instead of blown and inhaled a dried pea.

NICHOLAS RICHARDS

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¹ Heinlich, H J, *Journal of the American Medical Association*, 1975, **234**, 398.

Antibiotics and purulent sputum

SIR,—Drs N C H Stott and R R West deserve to be congratulated for their well-conceived and executed trial (4 September, p 556). Their demonstration of the closely parallel natural history of antibiotic- and placebo-treated respiratory illness where purulent sputum is the principal abnormality reported or found should encourage many more doctors to treat such illnesses expectantly.

During last winter we attempted a similar study on male patients in a number of practices in the Aberdeen area. The number of patients who completed the study (28) was too small to merit detailed statistical analysis, but the overall trends appear to confirm the Cardiff findings except in one aspect—the effect of smoking. A summary of the morbidity in tetracycline- and placebo-takers and in smokers and non-smokers in our study is shown in the table.

These findings suggest that whereas there is no obvious clinical advantage in being an antibiotic-taker as against a placebo-taker, there is a benefit in being a non-smoker as

	Patients	Mean duration of purulent sputum (days)	
		After starting treatment	Total illness
Non-smokers	13	4.7	7.2
Antibiotic-takers	12	6.3	11.1
Placebo-takers	16	6.8	10.3
Smokers	15	8.1	13.6

against a smoker. Further analysis showed that smoking antibiotic-takers produced purulent sputum for significantly longer than did non-smoking placebo-takers. These results are in keeping with the trend reported in a previous study of similar design¹ (to which Drs Stott and West referred) and it is perhaps surprising that they have not been confirmed in the Cardiff paper. Could it be that the inclusion of female patients has masked another of the disadvantages of being male?

It is a pleasure to acknowledge the help given by ICI Ltd for the provision of materials and finance for this study.

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¹ Howie, J G R, and Clark, G A, *Lancet*, 1970, **2**, 1099.

Chronic urticaria

SIR,—I was delighted to hear that Dr Anne E Solomon and Miss J Macaulay (25 September, p 758) have established a separate clinic to study patients with urticaria and do hope that some new ideas in aetiology and treatment will evolve.

They mention some of their results in 37 patients with chronic urticaria and I would like to make some comments on these. Using a challenge test battery they had reactions in only four patients. In 1976¹ we recorded that out of 111 patients with chronic urticaria tested, 15 had shown a reaction to brewer's yeast, 12 to sodium benzoate, and 14 to tartrazine. It was at this time pointed out that these results were very much less than those recorded in previous reports, but it is certainly surprising that Dr Solomon and Miss Macaulay did not have more patients with reactions. However, what worries me much more about their results is that apparently only one patient reacted to test doses of aspirin. I simply do not understand this as it is completely against previous figures for patients with chronic urticaria who have shown exacerbations after having test doses of aspirin.²⁻⁶ In all these series the numbers of patients who have shown a reaction to salicylate test doses has ranged from 20% to 40%—the latter figure occurring when very high doses were given. Moreover, it has been demonstrated in the past few years that a large number of asthma sufferers show a similar exacerbation after salicylates.⁷⁻¹⁰

Assessment of the challenge test battery in patients with chronic urticaria can be difficult because chronic urticaria fluctuates so much and exacerbations may well occur after emotional upsets or upper respiratory tract infections, etc. Attacks of the weals during the test period may therefore have explanations other than a reaction to the particular chemical being tested and, indeed, at times attacks may coincide with taking the placebo capsules. It is therefore essential that the tests are repeated at least once, preferably administered in a