reported to arrest haemorrhage from oesophageal varices in a proportion of cases for periods ranging from hours to months,¹⁻⁶ but haemorrhage recurred in some patients when the cannula was removed.^{2,4,6}

The effectiveness of thoracic duct cannulation for bleeding oesophageal varices is still a controversial matter. In spite of this, I think that the policy that should be adopted is to perform cannulation of the thoracic duct in patients not fit for major emergency operation. If this minor palliative procedure succeeds in preventing further bleeding the patient can be better prepared for a portacaval shunt operation that can be conducted a few days after his general condition has improved.

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¹ Dumont, A E, and Mulholland, J H, *Annals of Surgery*, 1962, **156**, 668.

² Bowers, W F, et al, *Journal of the International College of Surgeons*, 1964, **72**, 71.

³ Cueto, J, et al, *Annals of Surgery*, 1967, **165**, 408.

⁴ Kessler, R E, et al, *Gastroenterology*, 1969, **56**, 536.

⁵ Dumitrescu, I, et al, *Chirurgia (Bucharest)*, 1973, **14**, 529.

⁶ Datta, D V, et al, *Gut*, 1971, **12**, 48.

Diabetic ketoalkalosis: a readily diagnosed non-entity?

SIR,—We have watched with interest the reaction to Drs K C Lim and C H Walsh's recent short report on this subject (3 July, p 19). While reluctant to perpetuate the correspondence, we feel that a challenge should be made to this new term.

We would suggest that in all the cases cited by Drs Lim and Walsh, Dr Elaine B Melrose and others (24 July, p 237), and Mr R Shirley and Dr Jennifer V Martin (16 October, p 943) to support this new entity of diabetic ketoalkalosis an alternative explanation on the basis of concurrent pathology is possible. Naturally the clinicians concerned must remain the final arbiters in a decision as to the validity of our alternative proposals.

In the prime paper Drs Lim and Walsh explain the metabolic alkalaemia on the basis of gastrointestinal losses and, in the second case, the additional factor of alkali ingestion.

In regard to the letter from Dr Melrose and her colleagues we feel that a closer examination of the case is required before it can be used as an example of the condition. While it was clinically similar to the two patients in the original paper, we think the biochemical results and interpretation may be erroneous. Recalculation of the results from the given P_{CO_2} and pH show that the standard bicarbonate should be approximately 25 mmol/l (assuming a normal haemoglobin concentration). Thus this is definitely not a metabolic alkalaemia and a respiratory cause is likely.

In the case reported by Mr Shirley and Dr Martin, unlike Drs Lim and Walsh's cases, the metabolic alkalaemia was not corrected on treatment of the diabetes. Our view is that this set of blood gas results may be shown by a patient with chronic obstructive airways disease whose normal compensated hypercapnic state has been disturbed by measures which reduce the P_{CO_2} . Unfortunately we are given no details of this aspect of the case.

We are delighted to see the encouragement of acid-base investigation in all cases of diabetic ketosis and appalled by its absence on occasion. These patients illustrate how mixed and unexpected acid-base disturbances can

present and the fallacy of assuming single pathology which may dictate inappropriate treatment. However, we feel that such cases are the exception rather than the rule and wonder whether the new term "diabetic ketoalkalosis" may not be best avoided in favour of an accurate description of the individual patient's problems, lest it become the latest popular diagnosis.

We would like to end by observing that an alkalosis was not demonstrated in any case, only an alkalaemia.

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Safety for children

SIR,—Apropos your sensible leading article (9 October, p 833) in which you point out that Britain has the worst child pedestrian casualty rate in Western Europe, could I suggest that when a motorist who runs over a child says that the child did not give him a chance the reply should be that he should not have taken or needed one. Surely it is the business of adults to avoid injuring children as they go about their business rather than that of children to be taught prematurely that life is a matter of safety first rather than exploration of the environment.

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Continuous fetal monitoring in the ambulant patient

SIR,—Dr Anna Flynn and Mr John Kelly (9 October, p 842) state that "until now, because of technical limitations, continuous fetal monitoring in labour has meant confining the patient to bed." This is not strictly true, as the technical ability to use telemetry for signals of this nature has been available for quite some time.^{1,2} The real limitation is financial, since a commercial system will cost in the region of £1500 for the telemetry alone, while home-made devices, though low in component cost, absorb considerable resources in terms of technical expertise.

It is not denied that mobility may confer certain advantages to patients in the first stage of labour and that a technique of monitoring which allowed ambulation might encourage obstetricians to keep their patients ambulant. However, we do suggest that the system described is not necessary and because of its expense may be counterproductive to encouraging ambulation. We have developed and are currently evaluating a small battery-powered warning monitor under a grant from the Equipment, Research, and Development Fund of the Scottish Home and Health Department. The fetal heart is detected by electrocardiography and, in its present form, the device is designed as a low-cost portable bedside monitor which has the advantage of not producing large quantities of paper to prove that progress is normal. However, we intend to evaluate a simplified version which could be worn by an ambulatory patient.

While this device simply gives warning of the presence of abnormal fetal heart rate patterns, which then require more detailed

study on a recording fetal monitor, we feel it may be a more cost-effective approach towards extending surveillance to ambulatory patients not in "at risk" categories.

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¹ Weller, C, and Manson, G, in *Biotelemetry*, ed H P Kimmich and J A Vos, p 13. Leiden, Meander, 1972.

² Manson, G, *Electroencephalography and Clinical Neurophysiology*, 1974, **37**, 411.

Is the cholera pandemic waning?

SIR,—Your leading article (14 August, p 390) on the waning of the cholera pandemic notes its involvement of "Africa south of the Sahara (probably for the first time in history)." Lest this suggestion that it is the first time trans-Saharan Africa has been affected is taken as correct, evidence to the contrary should be noted. Richard Burton experienced the ravages of cholera on the East African coast at Kilwa. James Christie in his classic work¹ described the cholera epidemics of East Africa, including their extension to the remote inland parts of Central Africa,² while Pankhurst³ has recorded the many epidemics of cholera in Ethiopia, which must have extended more widely. Finally, for West Africa, which Hirsch⁴ recorded has never been affected, Bowesman⁵ described the epidemic of cholera in Senegal and Gambia in 1869. This was referred to *The Times* while it was raging and Bowesman notes other mentions of this epidemic which, till he wrote, was unrecorded in the *Index Catalogue* and other indexing and abstracting sources. Curiously enough Dr Bowesman's own note seems to have escaped attention.

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¹ Christie, J, *Cholera Epidemics in East Africa*. London, MacMillan, 1876.

² Davies, J N P, *East African Medical Journal*, 1959, **38**, 1.

³ Pankhurst, R, *Medical History*, 1968, **12**, 262.

⁴ Hirsch, A, *Handbook of Geographical and Historical Pathology*. London, New Sydenham Society, 1886.

⁵ Bowesman, R, *East African Medical Journal*, 1959, **38**, 621.

Computer interrogation of patients

SIR,—I wonder whether Dr A L Jacobs's letter (2 October, p 814) is based upon his own practical experience of using computers in this manner or merely an assumption of some fundamental medical ethic.

We have been experimenting with the use of computers in this mode for the past six years in attempting to discover what actually happens during the doctor/patient interaction. It is now being routinely used in one of our medical outpatient clinics. In one of our earlier experiments with bronchitis patients we interviewed the patients as to their opinion. All of them preferred the computer terminal asking the questions to the doctor. The reasons were clearly spelt out: (1) the atmosphere was relaxed and friendly; (2) the machine did not shout at them or become irritable; (3) they did not feel they were wasting the great man's time; (4) they could ask for the question to be repeated without feeling foolish; (5) they could

be asked embarrassing questions without difficulty; (6) they could be asked questions not directly concerned with the reason for the consultation.

The doctor/patient relationship is a wonderful theoretical concept; a pity it is not universally applied. However, if a computer terminal can be programmed so that it can be introduced into this dialogue then perhaps the doctor's memory can be jogged, especially when he is tired or rushed and on repetitive routine questions. It appears to leave him time to talk to the patient. The computer interview lasted an average of 30 minutes, not three, which is so often the case in practice, and often asked questions the doctors overlooked about systems not directly related to what the patient came to see the doctor about.

Computers can be used in medicine in two ways, either to do the housekeeping or as an intellectual tool as an extension of the doctor's forebrain—for those of us who have any.

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Abnormal patency of the eustachian tube

SIR,—I would like to draw attention to a fairly common ear condition which frequently goes undiagnosed and is managed incorrectly. The condition of a patulous or "over-patent" eustachian tube has been written up in American¹ and Canadian journals but has had little attention drawn to it in Britain.

The patient complains of a sensation of blockage in the ear but paradoxically denies any marked hearing loss. The sensation of blockage disappears on lying down and frequently alters with certain positions of the head, particularly when the head is leant forwards. Patients may comment, or will note if asked directly, that they hear the noise of themselves talking, eating, or breathing in their ears. They have an "echoing" or "hollow" sensation in the ears. The more expansive and neurotic will complain of lightheadedness and a dizzy feeling. Examination shows a normal tympanic membrane and closer examination will occasionally show that the drum moves in and out on respiration when the mouth and opposite nostril are closed. The ENT surgeon will find a normal postnasal space on examination. The condition is frequently managed incorrectly as eustachian tube obstruction and the patient is placed on a decongestant tablet and nose drops. There is, however, no history of a previous cold or barotrauma and nasal symptoms are usually absent.

This curious but definite entity is seen in those who have lost weight, usually a relatively rapid and recent loss from dieting, those on the pill, and in pregnancy. I have also seen it in the older patient when placed on diuretics. The symptoms are usually minor and explanation and reassurance suffice as treatment. The management becomes more difficult when the patient is irritated by the failure of nasal decongestants (which, not surprisingly, may accentuate the symptoms) and by a conviction that the problem has not been fully understood. Occasionally symptoms are sufficiently marked to justify insertion of a grommet: this does lessen the ear complaints to a tolerable level. In the very rare instance when the patient is extremely distressed the injection of Teflon

paste into the region of the eustachian cushion to narrow the patulous eustachian tube has been effective.²

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¹ Pulek, J L, *Laryngoscope*, 1964, **74**, 257.

² Pulek, J L, *Laryngoscope*, 1967, **77**, 1542.

Management of appendicitis

SIR,—The situation with regard to wound drainage and antibiotic prophylaxis in cases of perforated or gangrenous appendicitis is not as clearcut as Mr A W Clark (9 October, p 881) would have us believe.

There is a lot of conflicting evidence about the use of wound drainage, as pointed out in a leading article in the *Lancet* in 1971.¹ Magarey's study² was discussed in that article and it was emphasised that he used intraperitoneal drains placed through the wound, not necessarily the best method. Then in 1973 Farrar³ reported a prospective trial of closed suction extraperitoneal wound drainage which failed to demonstrate any reduction in wound infection. In relation to systemic antibiotics, a three-dose regimen of cephaloridine failed to reduce the incidence of wound infection in cases of perforated appendicitis, although the overall incidence of wound infection in general surgical wounds was significantly reduced.⁴

As a result of a recent, as yet unpublished, study⁵ we are able to provide further information which we hope will help to clarify the situation. In a controlled, prospective, randomised trial we have shown that in patients with a gangrenous or perforated appendix: (1) the use of a 3-day course of cephaloridine, started preoperatively, reduced the wound infection rate from 84.2% (control) to 40%; (2) the use of an extraperitoneal wound drain alone significantly reduced the wound infection rate from 84.2% to 50%; and (3) the use of both together reduced the wound infection rate even further, from 84.2% to 21.4%.

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¹ *Lancet*, 1971, **2**, 195.

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

³ Everson, N W, *et al*, In press.

⁴ Evans, C, and Pollock, A V, *British Journal of Surgery*, 1973, **60**, 434.

⁵ Farrar, D J, *et al*, *British Journal of Clinical Practice*, 1973, **27**, 63.

SIR,—As an alternative to delayed suture for cases of suppurative appendicitis, as discussed by Mr A W Clark (9 October, p 881) and Mr G Qvist (30 October, p 1074), I have found that the following technique yields satisfactory results.

The musculoaponeurotic layers are brought together with a minimum number of interrupted sutures. Several (generally three) deep cutaneous stitches are then inserted, bringing the subcutaneous fat very loosely into apposition but leaving the skin edges gaping. Finally, these edges are brought together with a larger number of fine sutures which do not penetrate deeper than the skin itself; a small subcutaneous drain is inserted into the lower end of the wound. Antibiotic cover is given from the time of operation.

Profuse discharge occurs from the drainage site for several days, but a clean and neat suture line generally results.

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Recruitment to community medicine

SIR,—The inadequate recruitment of young doctors to the specialty of community medicine is currently causing some alarm. Although the quality of those in training is for the most part excellent, their numbers are insufficient even to replace losses due to death and retirement.

The report of the Working Party on Medical Administrators, of which I was chairman, stressed that for the foreseeable future one source of recruitment to the specialty would need to be mature entrants. The working party had in mind particularly clinicians with managerial experience gained by membership of Cogwheel committees and, since reorganisation, of district management teams. The report recommended formal arrangements for training and in-service experience for these doctors and emphasised their suitability for particular specialist posts.

At present there is no evidence that such formal arrangements exist and I suspect this valuable recruitment pool is largely untapped. In view of the manpower crisis facing community medicine has not the time come for those concerned with the future of the specialty to reassess present policy on recruitment and existing training arrangements?

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Expansion of the medical schools

SIR,—Mr F S A Doran (20 November, p 1272) indicates that on the present trend towards 2.9 juniors to each hospital consultant there will never be enough home-produced doctors to staff the hospital service. Parkhouse and McLaughlin¹ also stressed the impossibility of adequate junior staffing of hospitals, even though enough general practitioners can be provided. Parkhouse² has further suggested that the "cushion of uncommitted junior staff in hospital is not likely to continue indefinitely" and he suggests a redistribution of grades within the hospital service as one possible solution.

Traditional methods of working require re-examination from time to time and now may well be the opportune moment to consider whether hospital doctors (physicians, surgeons, paediatricians, geriatricians, and psychiatrists) really need to be supported by junior staff any more than do general practitioners. In many American hospitals, for instance, there are no juniors, and no doubt the same applies in other parts of the world. If the consultant establishment were increased to allow a group of, say, five or six physicians (or paediatricians or geriatricians) to be based on one district general hospital the total number of patients that each would care for would be diminished and each should then be able to provide total care for his own patients. Such numbers would also allow a reasonable on-call rota for each group.

Advantages that would accrue from such an arrangement would be not only elimination of