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