are my consultant colleagues. A general impression only was intended to be conveyed of the junior staffing situation during the time I have spent as consultant ophthalmologist in Barchester and district.—I am, etc.,

"P. GILLIVAN."

Barchester.

Haematemesis and Melaena

SIR,—In their admirable article (4 April, p. 7) Dr. K. F. R. Schiller and his colleagues report reduced mortality rates in bleeding peptic ulcer, especially in elderly patients, when a conservative operation was used instead of gastrectomy. They conclude that vagotomy plus drainage and over-sewing of the ulcer is the procedure of choice. I hope that surgical trainees will not conclude that a standard operation of this type is indicated in all cases irrespective of the general condition of the patient and the site and pathological state of the ulcer. As there is no mention in the paper of the effect which these factors might have on the choice of operation, I suggest the following general principles are relevant.

Over-sewing of a peptic ulcer cannot be guaranteed to prevent recurrent haemorrhage if the ulcer crater is large and its edges rendered pliable by inflammatory oedema or fibrosis. On the other hand with a small soft-walled ulcer suturing is safe and effective, provided cat-gut is used, so as to avoid the development of a foreign body sinus or ulcer.

Excision of a large indurated ulcer is preferable to over-sewing as healthy tissues may then be sutured together. This is applicable in the case of an anterior duodenal ulcer during pyloroplasty and to some gastric ulcers with or without a curative procedure, depending upon the general condition of the patient.

The most serious problem involves the large penetrating posterior duodenal ulcer, which of course cannot be excised with safety. In this type of case only gastrectomy with closure of the duodenal stump distal to the ulcer crater offers maximal security against further bleeding. Tamponade of the crater by tying marginal sutures over a pad of fat is effective once the ulcer has been excluded from the gastro-intestinal stream. It need hardly be added that this is a job for an experienced gastric surgeon, who should therefore always be on hand when any exploratory operation is carried out for gastro-duodenal haemorrhage.—I am, etc.,

NORMAN GIBBON.

Liverpool.

Clear Labelling

SIR,—The March edition of *B.M.A. News* draws attention to the value of writing N.P. on most prescriptions so that drug containers will be clearly labelled with the name and strength of the preparation. It also reminds us that this policy has been supported by the B.M.A. for many years and by the Committee on Safety of Drugs more recently. Perhaps the moves in this direction could be accelerated by the addition of the printed letters N.P. to the

E.C.10 forms? Prescribers could still delete these letters if necessary.—I am, etc.,

JAMES S. STEWART.

West Middlesex Hospital,
Isleworth.

Pregnancy and Crohn's Disease

SIR,—The survey by Dr. J. F. Fielding and Dr. W. T. Cooke (11 April, p. 76) of married women with Crohn's disease certainly suggests that pregnancy is not particularly hazardous.

However, having strong personal memories of the case reported by Blair and Allen¹ I should like to reiterate the very serious prognosis when Crohn's disease presents acutely for the first time in pregnancy. They surveyed the literature and found seven cases where this happened. In all seven, premature labour occurred and four of the babies died. At least one² and probably another³ of the mothers died. It would appear that "regional ileitis beginning during pregnancy constitutes a serious threat to both the fetus and the mother."—I am, etc.,

A. H. IMRIE.

Jessop Hospital for Women,
Sheffield, Yorks.

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Blue Light and Jaundice

SIR,—Your leading article on blue light and jaundice (4 April, p. 5) was welcome in drawing attention to this method of treatment which, though first developed in Britain, has been almost totally neglected here ever since. However, you seem not to have been convinced firstly, that hyperbilirubinaemia unassociated with haemolytic disease is potentially dangerous, and secondly, that phototherapy is both effective and harmless. There is, however, plenty of evidence from both in vitro experiments and clinical observation that hyperbilirubinaemia is potentially dangerous. Kernicterus is such a serious condition that even if its incidence is low every effort must be made to prevent it from occurring.

Recent work by G. B. Odell and colleagues¹ has shown that the major factor determining brain damage in jaundiced infants is the fraction of bilirubin which is dissociated from albumin and therefore free to diffuse into cells. In a careful study of infants who had been jaundiced during the neonatal period they found no correlation between the presence of brain damage at five years of age and the maximal serum bilirubin level, but that there was a significant correlation with the saturation of serum proteins with bilirubin in infancy. The saturation index provided a better assessment of the risk of hyperbilirubinaemia than did the serum bilirubin concentration. Their series of cases included one infant with brain damage in whom the maximum serum bilirubin concentration was

only 13.6 mg./100 ml., but the saturation index was abnormal. The risks are therefore greater in infants with hypoproteinaemia. In practice it still remains difficult, however, to assess accurately when a jaundiced infant is in danger because, as your article points out, other factors like anoxia, respiratory acidosis, and the respiratory distress syndrome may be involved. But it is precisely when these conditions are present that exchange transfusion as a method of treatment becomes more difficult and dangerous. We submit, therefore, that in such circumstances the simple method of phototherapy is particularly valuable and, provided it is properly given, its effectiveness is unquestionable. It has one great advantage—that is that the infant can be effectively treated in the incubator without undue disturbance.

The dangers of phototherapy are at present hypothetical. No ill effects have been noted in any of the numerous reports which have so far been published on this method of treatment. It seems likely therefore that its dangers have been exaggerated. We would, however, agree that long-term follow up studies of treated cases are desirable and so in Chelmsford, where we have now treated over 500 cases, a follow-up study has been started.

R. E. Behrman and D. Y. Y. Hsia² summarized the conclusions of the Chicago symposium. Your assessment appears to have overlooked the positive recommendation they made that "phototherapy should be used for infants in whom the risks of hyperbilirubinaemia are thought to outweigh the risks of this form of treatment." We disagree therefore with the opinion expressed at the end of your leading article that neonatal units are probably not justified in adding special lighting apparatus to the already long list of important equipment needed from limited funds. While we agree that the indiscriminate use of phototherapy should be discouraged, we maintain that more should be done to stimulate research into its correct application in suitable cases.—We are, etc.,

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St. John's Hospital,
Chelmsford, Essex.

P. M. G. BROUGHTON.

Department of Chemical Pathology,
University of Leeds, Yorks.

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Pancreatic Extracts

SIR,—With regard to the recent *Today's Drugs* article on pancreatic extracts (18 April, p. 161), I should like to record a further side-effect of these preparations recently seen in three patients attending the cystic fibrosis clinic at this hospital.

Two of the children were taking Pancrex V powder, and the third Pancrex V Forte tablets. In addition they were receiving oral antibiotics because of chronic lung involvement. They presented with severe mouth ulceration and angular stomatitis causing dysphagia, loss of weight, and pyrexia. Bacteriological cultures from the ulcers were

negative, and full blood counts and serum folate estimations were normal.

On close questioning the mothers had noticed that the children held the Pancrex powder (given in orange juice) in the mouth for some time before swallowing it, and in the third case the child crunched the tablets before swallowing them. The ulceration was thought to be due to digestion of the mucous membrane by the Pancrex extract in the alkaline medium of the mouth, and rapid clinical responses were obtained by stopping the Pancrex therapy and administering bland mouth washes.

It would seem important therefore to stress to parents and children the need to swallow these extracts quickly to prevent their activation in the mouth. The manufacturers, Paines and Byrne Ltd., have been informed and are labelling the preparations accordingly.—I am, etc.,

CARYL W. DARBY.

Hospital for Sick Children,
London W.C.1.

Long-term Anticoagulant Treatment after Myocardial Infarction

SIR,—Your leading article on long-term anticoagulant treatment after myocardial infarction (28 February, p. 514) unfortunately and unnecessarily alarmed physicians who safely treat their patients with anticoagulants and patients who benefit from these drugs on the condition that they are administered with the proper care.^{1 2}

In Holland an organization known as the "Thrombosis Service"³ is available to help the physician achieve a level of hypo-coagulability which lowers the mortality and the morbidity significantly in outpatients suffering from coronary and peripheral atherothrombosis.⁴ Several other studies have been performed outside Holland which confirm the statement that stable and intensive anticoagulation results in an improved prognosis for coronary thrombosis.^{5 6} One of the most recent reports referring to women appears to prove that even moderate anticoagulation is successful.⁷

Finally, it must be stated that the extensive experience in Holland, covering many tens of thousands of patients, has proved that the risk of haemorrhagic complications is small and perfectly acceptable. A reasonable interpretation of the available data might read as follows: adequate anticoagulant treatment has proved to offer a clearcut, although minor, contribution

to longer and better survival of patients suffering from atherothrombosis.—I am, etc.,

E. A. LOELIGER.

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Department of Medicine,
Leiden, Holland.

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The Ophthalmic Service

SIR,—A publication entitled *The Ophthalmic Service* (February, 1970) from the Office of Health Economics describes the functions of the General Ophthalmic Service. It is perhaps unfortunate that it did not before publication receive the agreement of the representatives of all the interested groups taking part in this service, since this would have ensured the greatest possible accuracy of the text. It describes the history of the Supplementary Ophthalmic Service, which has become the General Ophthalmic Service, and the routine examination of sight which the service provides. There is perhaps some doubt whether all the facts are quite accurately presented.

It becomes evident in the latter part of the publication that the General Ophthalmic Service is heavily subsidized by the sale of private spectacle frames to patients who have been examined under this part of the National Health Service. This, it states, "heavily weights his (the ophthalmic optician's) activities in favour of dispensing and militates against a trend towards general eye care." It appears that if ophthalmic opticians are to develop the role of general eye care, "restructuring of the system of fees" will be required. It seems to be unfortunate that the ophthalmic opticians are unable for economic reasons to carry out the primary work for which they have been trained.—I am, etc.,

A. G. CROSS.

London, W.1.

Second Green Paper

SIR,—At a special meeting which the medical advisory committee of the Durham Group of Hospitals called to discuss the second Green Paper¹ the proposed administrative structure was rejected because:

(1) It failed to provide a logical and cohesive structure to replace the existing patterns of management;

(2) It advocated a separate statutory organization for the family practitioner service which militates against the unification it seeks to achieve; and

(3) The administrative and political expedient of relating the new structure to a reformed local government would offer no particular benefit in the provision of total health care.

If the service is to be re-structured to meet the objectives of the Green Paper there is a need first to evaluate the opinions now being collected as a result of this stimulus to discussion, and then to produce recommendations which will provide a clear and logical structure for a new service. This exercise requires the skill and judgement of experienced people from all branches of the existing services. For this reason we have written to the Secretary of State urging him to set up a national working party to consider the views and opinions collected in response to the second Green Paper, taking whatever further evidence is considered necessary, and thereafter advising on the future pattern to be adopted for providing

comprehensive health care. That working party should be fully representative of all the organizations concerned with this massive re-structuring of a social service, and should include management consultants.

We ask for support for this suggestion from all medical advisory committees, because we believe that this is the only way in which a properly structured health service can be achieved.—We are, etc.,

A. ZINOVIEFF,

Chairman,
Medical Advisory Committee.

ALAN WILSON,

Honorary Secretary,
Medical Advisory Committee.

Dryburn Hospital,
Durham City.

REFERENCE

- 1 Department of Health and Social Security. *The Future of the National Health Service*. London, H.M.S.O., 1970.

Function of "Medical Register"

SIR,—Major C. K. Davies (18 April, p. 181) raises the question of the inclusion in the *Medical Register* of additional qualifications such as M.R.C.O.G. and F.F.A.R.C.S.

Such qualifications have hitherto been excluded from the *Register* as a result of the inflexible terms of the Medical Acts. The General Medical Council has been unhappy about this for many years, and accordingly sought and obtained, in section 11 of the Medical Act 1969, authority to include in the *Medical Register* "any additional qualification which the council determine ought to be registrable." The council is currently considering which postgraduate qualifications should be registrable under this new power, and it seems likely that, before the *Medical Register* 1971 is published, a wide range of additional qualifications including the M.R.C.O.G. and the F.F.A.R.C.S. (which he mentions) will have become registrable.

The G.M.C. has recently abolished the fee of £1 formerly charged for the registration of an additional qualification, but problems of identification would make it difficult to implement Major Davies's suggestion that all qualifications obtained by doctors should automatically be entered against their names in the *Register*. In future however any doctor who holds a registrable additional qualification need only inform the G.M.C. in order to secure its entry in the *Register*.—I am, etc.,

M. R. DRAPER,

Registrar,
General Medical Council

London W.1.

Vocational Registration

SIR,—Some of your readers may think the representatives of hospital doctors have been dilatory if the letter from Dr. P. J. Heath and Major P. J. Thompson passes without challenge (4 April, p. 52). The proposals in Sir George Godber's letter have by no means been accepted by the hospital side of the profession (see C.C.H.M.S. debate, *Supplement*, 7 March, p. 71). Seniors and juniors alike reject compulsory general professional training and specialist registration. Equally, we agreed that the proposed Central Council for Postgraduate Medical Education and