Ulcer healing, hospital admission, and bed rest

SIR,—All those interested in ulcer therapy will have read with interest and profit your leading article on new drugs for peptic ulcer (12 July, p 95). One statement, however, deserves comment. It is stated that bed rest accelerates ulcer healing and you cite as evidence the work of Sir Richard Doll and his colleagues at the Central Middlesex Hospital.¹

Doll's study showed that gastric ulcers healed more quickly in patients admitted to hospital than in those similarly treated on an ambulant basis¹; the various factors that may be relevant—that is, bed rest, supervised diet, and separation from home surroundings—are discussed, but it is nowhere stated that bed rest accelerates ulcer healing.

The role of bed rest in gastric ulcer healing has recently been formally studied in patients admitted to hospital, and it was found that those treated with bed rest (for 22 hours out of 24) did not heal their ulcers more rapidly than those who spent only eight to nine hours in bed.²

Those who treat ulcers can only work on the evidence available, namely that hospital admission accelerates ulcer healing,^{1,3} but it cannot as yet be assumed that bed rest plays any role in ulcer therapy.

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¹ Doll R, Pygott F. *Lancet* 1952;ii:171-5.

² Piper DW, Heap TR. *Scand J Gastroenterol* 1980; 15:113-7.

³ Herrman RP, Piper DW. *Am J Dig Dis* 1973;18:1-15.

Vomiting in association with cardiac pain

SIR,—It is interesting to see the report by Dr D A Ingram and others (6 September, p 636) confirming the view that vomiting in association with cardiac pain indicates major infarction rather than acute coronary insufficiency or patchy necrosis.

The more important diagnostic problem, however, is the one facing the general practitioner or cardiologist who sees an apparently fit patient with an attack of relatively slight or intermittent chest pain and who wants to know whether the patient is suffering from a coronary attack (whether infarction or unstable angina—both of which are dangerous) or some much less serious non-coronary disease. Here the occurrence of nausea or vomiting is of little help. In a series of 456 episodes of spontaneous chest pain personally investigated at the request of the general practitioner, nausea with or without vomiting was present in 71.¹ Thirty-six of these proved to have myocardial infarction, 20 non-coronary pain, eight spontaneous angina (coronary

insufficiency), and in seven the diagnosis was never established (see table).

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¹ Short D. *Brit Heart J*, in press.

SIR,—The article by Dr D A Ingram and others (6 September, p 636), concluded that: "when vomiting occurs early in association with cardiac pain, transmural infarction may be expected in 90% of patients." These authors made the distinction between transmural and subendocardial infarction on electrocardiographic criteria. That these criteria may be misleading was shown by the clinicopathological study of Raunio *et al*, where recent Q wave abnormalities consistent with so-called transmural infarction occurred in 20% of patients who were subsequently shown to have subendocardial infarction only; abnormal ST segment depression with no associated QRS abnormalities occurred in 17% of patients who were subsequently shown to have transmural myocardial infarction.¹ Subendocardial infarction can therefore not always be distinguished from transmural myocardial infarction on the basis of the absence or presence of QRS abnormalities.

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¹ Raunio H, Rissanen V, Romppanen T *et al*. *Am Heart J* 1979;98:176-84.

Genital herpes

SIR,—In your leading article on genital herpes (7 June, p 1335), the aside is made: "At one time pregnant women with genital herpes were advised to have a caesarean section, but in Britain careful observation has taken its place." No reference is given to support this asseveration. In view of the severity of neonatal generalised herpes simplex, strong reasons should be advanced for the abandonment of a prophylactic caesarean section.

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*.*The aim was to emphasise the need for careful screening. It is not disputed that women with proved genital herpes should be delivered by caesarean section, but mere suspicion of herpetic infection is not an indication for caesarean section. Women at high risk of genital herpes, such as those with previous culture-positive infection and those in other categories listed by Kibrick,¹ and by Nahmias and colleagues at the International Conference on Human Herpes Viruses at

Atlanta in March 1980, should be seen weekly from about the 32nd week of pregnancy. Swabs should be taken from the cervical os and from any suspicious lesions; if there is herpetic infection then a positive result is available in a few days. Additionally, a smear should be taken for Papanicolaou staining, which can give a positive result in a few hours. Kibrick has summarised the indications for caesarean section and normal delivery.¹—Ed, *BMJ*.

¹ Kibrick S. *JAMA* 1980;243:157-60.

High-risk groups and cervical cancer

SIR,—We read with interest your leading article (6 September, p 629), and we quote: "In 1977 (and previous years were similar) 2.5 million cytological tests were carried out, of which 24% were for women under the age of 25, in whom less than 0.5% of deaths occurred, and 33% of tests were on women aged 25-34, in whom less than 15% of deaths occurred. If resources are restricted is this a sensible way of spending them?" The leading article later concludes: "At present too much effort is spent in trying to detect cervical cancer in too young an age group where, even with 100% coverage and effectiveness, fewer than 10 of over 2000 deaths would be prevented." But what about the deaths prevented among the same women 10-15 years later? Similar reasoning would suggest that the rarity of rubella-damaged infants born to 14-year-old girls is evidence against a rubella vaccination programme for school girls. Surely the point of screening at-risk young women is so that one can detect and treat preinvasive disease in them, thereby reducing mortality from invasive disease in later life.

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SIR,—The leading article (6 September, p 629) does great disservice to those who work in a region with the lowest (11%) screening rate in the country. Wirral is little better (14%). In Aberdeen only one woman had invasive cancer of the cervix in 1979 following intensive screening programmes (personal communication from Dr E McGregor). On Wirral in 1979 there were 21 women with invasive cancer, of whom none had a previous cervical smear.

The only way to prevent invasive cancer and to reduce deaths from invasive cancer is to diagnose preinvasive cancer by means of cervical cytology in women from the age of 25 upwards. More than 90-95% of cases of preinvasive cancer are discovered at the first smear. Of smears received here this year, 61% were from previously screened women with negative smears. Some came from women of 55 to 65.

All women with sexual experience are at risk from cervical cancer. The greatest predisposing factor is sexual intercourse at an early age. If the natural history of the disease is that of dysplasia (5 years after first intercourse) carcinoma-in-situ (10 years after), and invasive cancer (15 years after), it follows that some schoolgirls receiving oral contraceptives now will develop carcinoma-in-situ by the age of 25. How else can we account for the

Final diagnosis in patients with attacks of chest pain with or without nausea and vomiting

	Total	Final diagnosis			
		Infarction	Spontaneous angina	Non-coronary	Doubtful
With nausea and vomiting	71	36	8	20	7
Without nausea and vomiting	385	148	61	129	47
All cases	456	184	69	149	54