anorectal abscess and a fistula in ano. The latter condition, because it communicates with the anal canal, clearly is not suitable for primary closure; but the former condition responds extremely well to this treatment. However, we accept that this diagnostic distinction is not always easy. When reporting the late results of 100 patients treated for anorectal abscess we discovered that seven patients were subsequently found to have a fistula.¹ We suspect that this was due to errors in the original diagnoses rather than to late complications of the abscess. This same study showed that 15 patients had a recurrent abscess within the succeeding two years and, more important, 78% of patients had no recurrence or complication.

More recently we have described the details of the operative technique when reporting its efficacy in treating a consecutive series of 150 patients.² We have also published the results of a randomised trial involving 219 patients with anorectal abscesses.³ This latter study showed that treatment by incision, curettage, and primary sutures was preferable to the conventional treatment as judged by the patient's comfort, healing time, time off work, and the incidence of recurrence. We continue to use it and recommend it for anorectal abscesses and for all other acute pyogenic abscesses.

D H WILSON

Accident and Emergency Department,
General Infirmary,
Leeds LS1 3EX

¹ Wilson DH. *Br J Surg* 1964;**51**:828-31.

² Jones NAG, Wilson DH. *Br J Surg* 1976;**63**:499-501.

³ Leaper DJ, Page RE, Rosenberg IL, Wilson DH, Goligher JC. *Dis Colon Rectum* 1976;**19**:46-50.

Hazards of surgical glove powders

SIR,—Your leading article (4 October, p 892) indicates that the risk of granuloma formation from glove powder is small, but there is now sufficient evidence to refute the anecdotes of many surgeons that the phenomenon does not occur "in their hands." I am among those who unwittingly have inflicted this iatrogenic problem on a patient and am stimulated to recommend a method which I believe reduces substantially the amount of powder left on surgical gloves.

When the gloves have been put on the hands I continue cleansing the gloves with povidone-iodine surgical scrub cleanser (Betadine) for a further minute. This agent contains non-ionic surfactants, which mobilise loose material on the rubber, and iodine, which combines with the starch to form blue-black starch iodide. The starch iodide acts as a visible indicator, is water soluble, and is washed off easily under running sterile water. The gloves feel tacky after this procedure—which, I believe, indicates that the lubricating powder has been substantially removed. I would be interested to hear if this simple method has been put to the elaborate scientific tests¹⁻⁴ that surround this subject.

IAN FRASER

University of Southampton
and Department of Surgery,
Royal Hampshire County Hospital,
Winchester

¹ Jagelman DG, Ellis H. *Br J Surg* 1973;**60**:111-4.

² Kent SJS, Burnand KG, Owen D. *Ann R Coll Surg Engl* 1975;**57**:212-4.

³ Henderson WJ, Melville-Jones C, Barr WT, Griffiths K. *Br J Surg* 1975;**62**:941-4.

⁴ Grant JBF, Davies JD, Jones JV. *Br J Surg* 1976;**63**:867-9.

Breast cancer trials—a new initiative

SIR,—Patients selected for inclusion in the trial of adjuvant systemic therapy proposed by Professor Michael Baum and others (13 September, p 742) would presumably have received conventional local treatment. Yet much of the controversy surrounding the management of early breast cancer revolves around the extent of the primary surgical procedure. Surely it is of crucial importance both to the clinician and, not least, to the patient to determine whether breast conservation is a reasonable alternative to mastectomy.

A randomised, prospective trial of adjuvant systemic therapy in patients treated with surgical techniques that conserve the breast would answer both questions posed by these investigators. Such a study would not only provide an assessment of the risks of recurrence but also determine the impact of adjuvant therapy on patients treated by less radical procedures. This alternative proposal deserves consideration and might commend itself to those clinicians reluctant to participate in recent clinical trials.

PETER WALDEN

London W11 3NG

Parity and breast cancer

SIR,—Dr K L Woods and others (9 August, p 419) recently reported an inverse association between parity and age at presentation of breast cancer. The report prompted an examination of this relationship among 611 cases of breast cancer and 1826 patients hospitalised with other diseases (controls) in the county of Glamorgan in South Wales. These data were collected as part of a population-based case control study performed in seven areas of the world in the middle and late 1960s, the details of which have been reported.¹ Glamorgan provided the population most similar to that used by Woods *et al.*²

The women with breast cancer were interviewed within a few days of diagnosis and the controls at the time of their selection as controls. The mean ages at presentation of nulliparous and parous women were 58.86 years and 57.26 years respectively ($P(2) = 0.15$). Among parous women the mean age at presentation did not decrease with increasing parity, as shown in the table. In fact, the data suggest if anything an increase in average age with increasing parity; however a similar relationship was evident when the age at interview of hospitalised controls was stratified by parity level. Thus there is probably no meaning to the trend in the cases.

The relative risk of breast cancer associated with being parous, at successive ages at interview, was also examined. If, as suggested by Dr Woods and his colleagues, pregnancy accelerates tumour growth among women who had a malignant transformation at an early age, cases of breast cancer diagnosed among

young women should have occurred predominantly among the parous subgroup and the relative risk of breast cancer associated with parity should be greater than 1.0. In addition, the protective effect previously observed to be associated with parity would have been largely restricted to cases diagnosed at an older age. The table offers little confirmation of the proposed hypothesis in the age groups noted by Wood (χ^2 (linear) trend) = 0.07; $p > 0.90$). Subdivision into narrower intervals of age at presentation within the range 55-65 years did not reveal any trend in relative risk.

All these analyses were repeated in a comparable population-based set of data from Boston, comprising 580 cases and 1736 hospital controls.³ The results were very similar to those in the Glamorgan data and did not confirm the observation of Dr Woods and his colleagues.

EDWARD TRAPIDO

Department of Epidemiology,
Harvard School of Public Health,
Boston, Massachusetts

¹ MacMahon B, Lin TM, Lowe CR, *et al.* *Bull WHO* 1970;**42**:185-94.

² Lowe CR, MacMahon B. *Lancet* 1970;**ii**:153-6.

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Mexiletine for supraventricular tachycardia

SIR,—The recent article by Dr Edward B Leahey and others on combined mexiletine and propranolol treatment of refractory ventricular tachycardia (2 August, p 357) prompts us to bring to your attention our experience with mexiletine in the management of resistant supraventricular tachycardia.¹

This concerns four patients in whom mexiletine corrected eight out of 10 episodes of supraventricular tachycardia. In five instances the prior administration of practolol with or without other drugs had been ineffective. In one a supraventricular tachycardia with aberrant conduction was mistaken for ventricular tachycardia and lignocaine was given without effect followed by mexiletine, which terminated it. This was our index case, which first led us to examine the effect of mexiletine on supraventricular tachycardias. In the remaining two instances mexiletine was the only drug used and successfully aborted the arrhythmia. In the two episodes in which mexiletine failed verapamil was also given in one and disopyramide in the other, but DC cardioversion was required in both.

Mexiletine until now has been advocated only for ventricular arrhythmias, but these results suggest a useful role also in supraventricular arrhythmias. It has a "class-1" anti-dysrhythmic effect on atrial as well as ventricular muscle, and has also been found in isolated rabbit atria to reduce the maximum driven frequency and the conduction velocity and to raise the electrical threshold.² It is also possible that in the five instances where practolol

Age and parity in breast cancer

Parity	..	..	..	1	2	3	4	5	>6				
Mean age at presentation	..	..	..	55.7	55.5	57.4	60.1	57.0	67.0				
No of cases	..	..	..	120	139	91	50	21	29				
Age at interview	..	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	>75	
Relative risk	..	2.0	0.7	1.6	0.6	0.4*	0.6	0.7	0.6	0.8	0.4*	0.6	
No of women (611 cases and 1826 controls)	..	..	11	37	194	306	291	334	339	323	276	186	140

* $p < 0.05$.