adults. Although vaccination of babies would be expected to increase the proportion of cases of mumps occurring in adults the absolute numbers would certainly fall if a high acceptance rate of vaccination were achieved. The need for a booster in late childhood, particularly in boys, could be met at high school at the same time as girls are given rubella immunisation. The disparity between the UK and the USA in attitudes to immunisation is curious and disturbing.

PETER MASTERS

Pathology Department,
Princess Margaret Hospital for Children,
Perth 6001

Management of patients after self-poisoning

SIR,—The decision taken by the colleges of physicians and psychiatrists—joint letter from the presidents (25 October, p 1141)—is a welcome one and has important implications for the hospital management of self-poisoned patients as well as for medical education and training.¹ Dr Dyer (15 November, p 1348) is right to attribute the refutation of the Hill report's² principal recommendation to a single study^{3,4} carried out at Addenbrooke's Hospital. He is wrong to suppose that he can discredit its findings with the comments he makes in his letter.

Our so-called "experiment" was a randomised trial lasting some 21 months in which we assessed 729 cases of deliberate self-poisoning consecutively admitted to hospital. As a result, the consultant physicians have, since November 1977, undertaken the initial psychiatric assessment of all their self-poisoned patients as part of the routine clinical work. The assumption, made by Dr Dyer,⁵ that the standard of the medical teams' assessments would deteriorate after the "experiment" has proved to be unfounded. At the clinical meeting in November 1979 to which he refers, I reported that the standard had been maintained—as measured by both the unchanged psychiatric consultation rate and the referral rates to psychiatric wards, outpatient clinics, and social workers.

Dr Dyer implies that it is the change in our assessment methods that has resulted in an increasing number of the self-poisoned patients seen in the accident department being denied admission to this hospital, and he misquotes a figure of 50% for these patients. The figures I gave at the meeting were 14% for 1975 and 35% for 1979 (until the end of September). I pointed out that these figures included some patients who had been transferred directly from the accident department to the psychiatric hospital at Fulbourn. Altogether in 1979 there were 642 patients who attended the accident department, of whom 30 were transferred to Fulbourn Hospital, and 424 admitted to Addenbrooke's Hospital. Hence 29% of the patients seen in the accident department were discharged back into the community, and not 50% as Dyer states. In fact it is the shortage of acute medical beds for all patients that has really been responsible for this trend.

Dr Dyer makes two further criticisms. The first is that according to Kennedy and Oswald⁶ our liaison scheme at Addenbrooke's is more expensive in terms of psychiatrists' time than the one at the Regional Poisoning Treatment Centre in Edinburgh.⁶ This assertion does not bear critical examination and has already been

rebutted in detail elsewhere.⁷ The second is that Blake and Bramble's⁸ study in Newcastle did not replicate our findings. The two studies differed in certain important respects. We ensured that our junior doctors and nurses were suitably taught as an integral part of our liaison scheme, and that the assessments were made by medical teams (nurses, house physicians, and medical registrars) under their respective consultant physicians. In Newcastle, the house physicians made their own assessments without any prior instruction. Nevertheless, they performed well enough to suggest that given suitable instruction they would, as members of their respective medical teams, be able to assess such patients properly.

R GARDNER

Addenbrooke's Hospital,
Cambridge CB2 2QQ

- ¹ Anon. *Br Med J* 1979;iii:1091-2.
- ² Joint Subcommittee of the Standing Medical Advisory Committees. *Hospital treatment of acute poisoning*. London: HMSO, 1968.
- ³ Gardner R, et al. *Br Med J* 1977;iii:1567-70.
- ⁴ Gardner R, et al. *Br Med J* 1978;iii:1392-4.
- ⁵ Dyer JAT. *Br Med J* 1978;iii:1491-2.
- ⁶ Kennedy P, Oswald I. *Br J Psychiat* 1979;135:92.
- ⁷ Gardner R, Hanka R. *Br J Psychiat* 1979;135:484-5.
- ⁸ Blake DR, Bramble MG. *Br Med J* 1979;iii:1763.

Endoscopic assessment of oesophageal disease

SIR,—It is a shame that the unfortunate experiences of Mr G Little and Mr H R Matthews (8 November, p 1269) should have led them to the conclusion that all patients with possible oesophageal disease should have barium swallow examinations before endoscopy is undertaken. If the three cases they describe are representative of others they have seen, then the lessons to be learned should really be that we should appreciate the limitations of each individual method of investigation and use these investigations in a sensible manner. We should also be aware of the natural history and complications of the pathological process with which we are dealing, and we should appreciate the complications of practical procedures we undertake.

Little and Matthew's first case describes an old man who was found to have a mid-oesophageal stricture. Knowledge of any other abnormality of the oesophagus and stomach below such a stricture is important before dilatation is attempted. A thin endoscope may pass the stricture making the insertion of a guide wire and Eder-Puestow dilatation a simple, safe procedure. Lack of information regarding the histology of a stricture need not necessarily delay dilatation, which may indeed facilitate the taking of biopsies. When the stricture is impassable, however, a barium study is mandatory before any dilatation is attempted. This applies equally whether the stricture is benign or malignant. In their second case it seems that the possible complications of a large para-oesophageal hernia were not clearly understood; perhaps the discussion of the case with an experienced gastroenterologist or thoracic surgeon would have led to the correct course of management. Barium studies would not have necessarily done so. It is difficult to see how the outcome of the third case was influenced by the lack of barium studies before oesophagoscopy. This man died of uncontrollable haemorrhage in theatre and would probably have done so whatever initial tests had been performed.

The lesson from these cases is not that all

patients should have both examinations, nor that all patients should have a barium swallow in preference to endoscopy. Endoscopy is probably the initial examination of choice, except where a pharyngeal pouch is thought to be a possible diagnosis. Endoscopy has the advantage of being able to allow a complete visual examination of the upper gastrointestinal tract; minor degrees of pathology such as oesophagitis and gastritis can be discerned better than with radiology, and biopsy and brush cytology specimens can be taken where necessary. Barium examination is necessary when the endoscopist has been unable to completely assess the upper gastrointestinal tract, and he should make a clear report regarding this, advising his colleagues accordingly. In the year ending 31 October 1980 over 1400 endoscopic examinations were performed in the endoscopy unit at this hospital. Of the 162 patients examined who had clinical oesophageal disease only 20% had had previous barium examinations. Twenty-eight Eder-Puestow dilatations were performed and eight oesophageal tubes were inserted. No case similar to those described by Little and Matthews has occurred. More investigations do not necessarily mean better management. They do mean higher cost, more wasted time, more patient discomfort, and less good patient compliance. The judicious use of the single investigation is far preferable to the obligatory use of a battery of tests.

DERRICK MARTIN

Department of Medicine,
Withington Hospital,
Manchester M20 8LR

SIR,—I read with pleasure and encouragement the Lesson of the Week by Mr G Little and Mr H R Matthews on the subject of endoscopic assessment of oesophageal disease (8 November, p 1269). They rightly state that endoscopy alone is an inadequate form of investigation of oesophageal disease [and that the complementary study of barium or gastrographin swallows examination must be undertaken].

I feel that one should go one stage further than this and say that in 1980 we should be able, in all departments undertaking oesophageal management, to perform cine barium studies in that the oesophagus is a dynamic organ and not an inert tube. Throughout the whole of the history of cardiac surgery we have had the facilities for cine films with regard to angiography, and I feel that it is high time that those of us trying to treat problems with this difficult organ—that is, the oesophagus—should have similar facilities. The production by the radiologists of one cut film for the assessment of, say, hiatus hernia is quite inadequate and a gross insult to the clinician.

M P HOLDEN

Freeman Hospital,
Newcastle upon Tyne NE7 7DN

SIR,—No sensible endoscopist, whether he uses rigid or fiberoptic instruments, believes that his examination necessarily gives all the diagnostic information which may be required. Mr G Little and Mr H R Matthews (8 November, p 1269), however, surely overstep themselves by suggesting that radiological studies of the oesophagus are invariably needed in addition to endoscopy in reaching a diagnosis.