relatively late in life, but that antibody levels, where present, showed little variation over a three-year period.

Serological evidence of widespread recent infections in children and adults with Coxsackie B3 virus corroborated reports of Bornholm disease in the area.

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DEATHS FROM POLIOMYELITIS AMONG BRITISH DOCTORS

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In our study of lung cancer and other causes of death in British doctors in relation to their smoking habits we have observed 34,494 medically qualified men over nearly five years—that is, from November, 1951, to September, 1956, a total of a little more than 165,000 years of exposure.* Over this time and in these 34,494 medical men there have been recorded eight deaths from poliomyelitis (including one certified as acute polioencephalitis). In relation to the size of the population at risk eight is a very small number. Yet it is greatly in excess of the number that would be expected to occur if doctors were dying of poliomyelitis at the same rate as adult males in the general population of Great Britain. Applying to our population of medical men these general population rates in the ten quinquennial groups from age 20 to age 70 (no deaths occurred in the general population over the age of 70) gives an expectation of only 0.83 deaths. It may be that persons in the higher social classes are rather more at risk of contracting poliomyelitis than those in the lower social classes. That would be in accordance with some modern beliefs—though we know of no statistical evidence in this country in its support. But even making them three times as vulnerable we would not expect more than two or three deaths to put against the eight observed. It therefore seems that doctors are specially at risk either of contracting poliomyelitis or, having contracted it, of dying from it.

*In our previous report (Doll and Hill, 1956), the total number of years of exposure observed was referred to as 148,686, but at that time data were available for deaths occurring only until March, 1956.

All those who died were relatively young men. At time of death their ages (last birthday) were 28, 30, 30, 32, 36, 37, 39, and 41. In their work there was no evidence of special risk—for example, in a laboratory. Their last known appointments were hospital casualty officer, hospital medical officer, chest physician, orthopaedic hospital officer, and general practitioner (4). These appointments were widely scattered—London (2), Middlesex, Berkshire, Kent, Staffordshire, Yorkshire, and Lincolnshire. In time, on the other hand, the deaths were curiously concentrated, since five of them occurred in August and September, 1952. The poliomyelitis season in this country is such that one would expect deaths to be specially concentrated in those months, but in each of the 1953 and 1956 seasons there was but one death of a doctor from poliomyelitis and in 1954 and 1955 there was none. The eighth death occurred at the end of the 1951 season (January, 1952). On the other hand, the total number of adult male deaths from poliomyelitis in Great Britain in 1952 (98) was the same as in 1953, not very different from the number in 1955 (105), and only about double that in 1954 (46 deaths) and, it seems likely, 1956.

Summary

The evidence given here suggests that men between the ages of 25 and 45 who are practising medicine in Great Britain are at special risk of dying of poliomyelitis. The actual number of deaths recorded (8) is small in relation to the number of men at risk (nearly 35,000), but at the rates of the general population not more than one death would have been expected to occur.

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INVESTIGATION OF NON-ULCER DYSPEPSIA BY GASTRIC BIOPSY

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Large numbers of patients with dyspepsia come to hospital, and often, in spite of appropriate investigations, no cause for it can be found. Although symptoms may abate when a patient learns of negative findings they often persist, and treatment may be difficult and unsatisfactory. A nervous cause of the indigestion may be suspected, but it is difficult to prove. In fact, dyspepsia of unknown aetiology constitutes a notable clinical problem.

Gastritis has long been suggested as a cause of non-ulcer dyspepsia, but in common with others we have found its diagnosis by gastroscopy far from certain (Wirts *et al.*, 1951; Shallenberger *et al.*, 1951; Palmer, 1952; Debray *et al.*, 1953; Selesnick and Kinsella, 1953). The suction biopsy tube introduced by Wood *et al.* (1949) offered a new means of obtaining information