no immigrant leaves the port health area unchecked.

May I suggest that in addition to the members already recruited for the B.M.A. working party the services of an experienced mass radiography unit director are secured. The planning and organization of a large number of people through a chest x-ray apparatus is a part of the normal work of a mass radiography unit medical director.—I am, etc.,

F. J. H. WALTERS.

Mass Radiography Service,
S.W. Metropolitan Regional Hospital Board,
Worcester Park,
Surrey.

SIR,—As regards the medical examination of immigrants, which is under discussion at present, I would like to advocate that Mantoux testing should be carried out as well as mass radiography. We have had quite a number of them as patients here with bone and joint tuberculosis without there being a demonstrable chest lesion. This might apply more to the immigrant from Aden than to the person from Pakistan, but this is only an impression. If the Mantoux test proved to be negative, B.C.G. could then be offered, and I think in many cases it would be readily accepted.—I am, etc.,

King Edward VII
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Sheffield 6.

E. G. HERZOG.

Treatment of Ulcerative Colitis

SIR,—I was most interested to read of the experiences of a double-barrelled ileostomy in ulcerative colitis and Crohn's disease of the colon by Dr. S. C. Truelove and others (16 January, p. 150).

Having had a relatively extensive experience of these diseases, particularly of ulcerative colitis, I am rather dismayed at the advocacy of what appears to me to be a retrograde step which, if generally adopted, will perpetuate the miseries of many patients. I feel the time has come for the frank expression of experiences. After many years two principles of the surgical management of ulcerative colitis seem to have emerged. Firstly, that the faecal stream should be totally diverted from the inflamed and ulcerated colon by an ileostomy, and, secondly, after much tribulation and sacrifice, that a complete restoration to health cannot be achieved without ablation of all the diseased bowel. Recrudescence of the disease, sometimes fulminating, has occurred where any of the colon has been retained and complications remote from the bowel may still occur (iridocyclitis, arthritis, pyoderma, etc.).

A special study has been made in this centre of changes in the colon which represent a stage of the disease from which no recovery has occurred in spite of the use of *all known medical measures*. These changes, which can be recognized radiologically, have been followed in patients for months and years, and a relentless progression of the disease has been noted.¹ Many centres with a special experience of ulcerative colitis report a risk of carcinoma, when the disease has been present for ten or more years, that would terrify those concerned with the suppression of smoking had it been related to lung cancer. To me this risk justifies a prophylactic colec-

tomy when the disease has been radiologically apparent for ten years or as soon as the patient himself comes to appreciate his position when irreversible signs have appeared. To continue to treat a disease which has become irreversible is merely to squander blood and expose patients to the continued use of adrenal corticosteroids, which themselves have come to be associated with sinister and sometimes dangerous effects.

Most surgeons with a special interest in ulcerative colitis have come to appreciate that their patients are of a dependent personality, have become demoralized by the repeated failure of medical measures, and are in urgent need of a treatment in which they may have full confidence. The psychological preparation, support, and follow-up of patients accepting the surgical cure of their condition far outweighs the technical arguments of the excision. From close observation of a personal series of almost 100 total colectomies without mortality, I have come to feel that in most instances attempts to preserve the colon had been unjustified. The account of the fates of patients in Table I makes unhappy reading. What cannot be expressed in such a table is an account of the individual privations, unemployment, the ugliness associated with steroid administration, shattered romances, and the miseries of a diet which is sometimes so restricted that the quality of life assumes the drabness of a mere existence. These features have certainly been the lot of many of my cases before surgery. My experience has been that the patient's recollections of past and failed surgical adventures enormously magnify his difficulties in his adaptation to a properly constructed permanent ileostomy. From the purely technical viewpoint the presence of scarring in the right iliac fossa from a previous ileostomy which has been closed at some stage prejudices the adhesive potential of the many excellent appliances on the market at the present time.

I have been constantly impressed by the gratuitous remark of the majority of members of a division of the Ileostomy Association that they wish they had been offered the surgical cure of their condition at a much earlier stage, when they could have avoided many months of anxious despair at a time when they could least afford it.—I am, etc.,

Department of Surgery,
The Medical School,
University of Newcastle upon Tyne.

F. C. WALKER.

REFERENCE

- 1 Walker, F. C., and Curtis, G. T., *Brit. med. J.*, in press.

Steroid Addiction in Ulcerative Colitis

SIR,—I was stimulated to write and comment on the letter on steroid addiction in ulcerative colitis (12 December, p. 1528) in that I am one of those who, according to Dr. M. Kelly, have "shut their eyes to the presteroid death rate in colitis of less than 2% per year." Though his presteroid mortality rate was in error, and your reply to his letter significantly lessens his arguments opposing steroid therapy to my satisfaction, I would like to call to your attention that one of the "steroid protagonists" has compared the death rates in colitis before and after steroids,¹ as he required, with a mean follow-up in the steroid era (9 years) reason-

ably approaching that in the presteroid era (12 years). This study revealed a fall in mortality rate from 21 to 12%. Most of the steroid-era deaths occurred early in the decade when experience was just being accumulated with hormonal therapy. The mortality rate of ulcerative colitis in the steroid era would be still smaller if it represented in addition the milder cases not treated with steroids.

I am sensitive to Dr. Kelly's expressive reaction to steroid therapy in ulcerative colitis when I recall the occasional case when a fatal complication had been steroid-accentuated. More optimistically, however, the course of ulcerative colitis has been altered by steroid therapy, so that the severe attack is terminated more swiftly, the patient is more likely to be completely well between attacks and spend less time in the hospital, an opportunity is offered for more elective and less urgent surgical procedures, and the fatality rate is markedly lessened. All of these advantages are proportional to the skill with which these drugs are utilized with regard to the natural course of the disease.

In summary, if one must have ulcerative colitis, he should prefer to have it in the steroid rather than in the presteroid era.—I am, etc.,

New York 28, U.S.A. BURTON I. KORELITZ.

REFERENCES

- 1 Banks, B. M., Korelitz, B. I., and Zetzel, L., *Gastroenterology*, 1957, **32**, 983.
- 2 Korelitz, B. I., and Lindner, A. E., *ibid.*, 1964, **46**, 671.

Double-barrelled Ileostomies

SIR,—I was most interested in the excellent article on the above subject by Dr. S. C. Truelove and others (16 January, p. 150), but was rather concerned that such authoritative people should use terminology so loosely. I had to read their opening paragraph several times before I realized that two quite separate ileostomies were described by them as "double-barrelled."

I do not wish to quibble, but as the operation of double-barrelled ileostomy has already been used in this condition one feels it is highly misleading to use the term for a quite different operation.—I am, etc.,

Ashford, Middlesex.

ROBIN BURKITT.

Post-mortem Caesarean Section

SIR,—I was particularly interested in your leading article on post-mortem caesarean section (23 January, p. 204), as apparently I am one of the few doctors who have performed the operation. I was pleased to learn that I had done the right thing in the right way.

About 30 years ago when I was in practice in Derby I was called urgently to a woman whom I had advised to get as much bed rest as possible because I found she had hypertension when nearing her confinement. I found her unconscious; not having an eclamptic seizure, but in a state of decerebrate rigidity, and decided she had suffered an intraventricular cerebral haemorrhage. She was obviously in a very bad way and while I was examining her and collecting my thoughts and telling the husband I was afraid she was going to die, she died.

We had been advised as students to carry a scalpel around when we were in practice in case we were called on to perform an emergency