- prophylaxis among surgical and medical patients. *BMJ* 1994; 308:235-46. (22 January.)
- Clagett GP, Anderson FA Jr, Levine MN, Salzman EW, Wheeler HB. Prevention of venous thromboembolism. *Chest* 1992; 102(suppl):391-407S.
 - Clagett GP, Reisch JS. Prevention of venous thromboembolism in general surgical patients. Results of a meta-analysis. *Ann Surg* 1988;208:227-40.
 - Collins R, Scrimgeour A, Yusuf S, Peto R. Reduction in fatal pulmonary embolism and venous thrombosis by perioperative administration of subcutaneous heparin. Overview of results of randomized trials in general, orthopaedic, and urologic surgery. *New Engl J Med* 1988;328:1162-73.
 - Leizorovicz A, Haugh MC, Chapuis FR, Samama MM, Boissel JP. Low molecular weight heparin in prevention of perioperative thrombosis. *BMJ* 1992;305:913-20.

Authors' reply

EDITOR,—Pulmonary emboli can be prevented either by antiplatelet therapy¹ or by anticoagulant treatment with subcutaneous heparin² (figure). More intensive antithrombotic effects could be achieved by more potent anticoagulant regimens, or by regimens that combine antiplatelet and anticoagulant therapies, and trials are in progress to determine which regimens offer the best balance of risk and benefit. But, pending the results of such studies, those responsible for surgical patients who are at appreciable risk of pulmonary embolism should be aware of how strong the randomised evidence already is for perioperative antiplatelet therapy. None of the points raised by Henri Bounameaux can cast serious doubt on this—indeed, many are already answered in the first and third parts of the antiplatelet overview.^{1,3} In particular, it has been shown that this conclusion is largely unaffected by restricting attention to particular categories of trials (such as those that were placebo controlled or that used venography rather than fibrinogen scanning to detect venous thrombi¹).

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On behalf of the Antiplatelet Trialists' Collaboration

Perioperative pulmonary embolism in randomised trials of antiplatelet therapy and of subcutaneous heparin

- Antiplatelet Trialists' Collaboration. Collaborative overview of randomised trials of antiplatelet therapy. III. Reduction in pulmonary embolism and venous thrombosis observed with

antiplatelet prophylaxis among surgical and medical patients. *BMJ* 1994;308:235-46. (22 January.)

- Collins R, Scrimgeour A, Yusuf S, Peto R. Reduction in fatal pulmonary embolism and venous thrombosis by perioperative administration of subcutaneous heparin. Overview of results of randomized trials in general, orthopaedic, and urologic surgery. *N Engl J Med* 1988;318:1162-73.
- Antiplatelet Trialists' Collaboration. Collaborative overview of randomised trials of antiplatelet therapy. I. Prevention of death, myocardial infarction, and stroke by prolonged antiplatelet therapy in various categories of patient. *BMJ* 1994;308:81-106.

Accuracy of peak flow meters

EDITOR,—We wish to reply to one of the letters¹ about our paper on the accuracy of mini peak flow meters in indicating changes in lung function in children with asthma.² We agree with T C Barrett and D A Spencer that it is important to address the issue of within child repeatability over time. We have made a complementary analysis of the data presented in our paper (submitted for publication elsewhere), in which we used generalised estimating equations³ and multilevel modelling⁴ to investigate and then adjust for the potentially complex correlation structures that may exist between repeated measurements of peak expiratory flow over time within a child.

The analysis in our paper was deliberately non-statistical, precisely because any quantitative analysis would have required the correlation structure to be taken into account and hence would have required a mathematical presentation. We believe that the qualitative manner in which we presented the data provides a fair summary of them, which leads to appropriate inferences. Furthermore, given the extreme nature of the non-agreement between the portable meters and the spirometer that we reported, it would have been extremely surprising if this had arisen solely as a consequence of our having ignored the correlation structure in our qualitative analysis.

Nevertheless, we wish to reiterate our agreement with the important points raised by Barrett and Spencer. We would be unhappy if anyone inferred from our simple presentation that it was unnecessary to consider the correlation between repeated measurements when analysing data such as these.

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- Barrett TC, Spencer DA. Accuracy of peak flow meters. *BMJ* 1994;308:917. (2 April.)
- Sly PD, Cahill P, Willet K, Burton P. Accuracy of mini peak flow meters in indicating changes in lung function in children with asthma. *BMJ* 1994;308:572-4. (26 February.)
- Liang K-Y, Zeger SL. Longitudinal data analysis using generalized linear models. *Biometrika* 1986;73:13-22.
- Goldstein H. Multilevel mixed linear modelling analysis using iterative generalized least squares. *Biometrika* 1986;73:43-56.

Is there an epidemic of cancer?

EDITOR,—We welcome the attention brought by David Coggon and Hazel Inskip to the large increase in death rates from oesophageal cancer over the past 30 years.¹ However, their conclusion on aetiological factors is flawed by relying on Office of Population Censuses and Surveys data, which fail to differentiate between the different histological types of oesophageal malignancy.²

It is widely accepted that smoking, and perhaps to a lesser extent, alcohol consumption, are important aetiological factors in the development of squamous carcinoma of the oesophagus. There is little evidence that either is implicated in adenocarcinoma of the oesophagus.³ One of

the most important observations is that adenocarcinoma is virtually unheard of in countries with a high incidence of squamous cancer of the oesophagus, and so a common aetiology seems most unlikely. Adenocarcinoma of the oesophagus seems to be a disease of highly developed countries and higher socioeconomic groups. There is increasing evidence of the link between gastro-oesophageal reflux disease, columnar metaplasia of the lower oesophagus (Barrett's epithelium), and transformation to adenocarcinoma.

Although both histological types of oesophageal cancer are increasing, centres specialising in the treatment of this disease are now seeing a dramatic increase in adenocarcinomas.^{4,5} In the past three years, 28 of 52 oesophagectomies in this unit have been for adenocarcinomas. There can be difficulty in differentiating adenocarcinoma of the cardia of the stomach from that arising in the oesophagus, particularly when a hiatus hernia is present, as both diseases have a tendency to longitudinal spread. However, the difference should be recognised by experienced endoscopists and pathologists, and our conclusion is that the incidence of both types is increasing. It is interesting to speculate whether some common aetiological factor for adenocarcinoma arises in the region of the oesophagogastric junction. True adenocarcinoma of the oesophagus almost always develops in metaplastic columnar epithelium. Whether chronic reflux that initiates the malignant change or some other carcinogen particularly affects this area of the gastrointestinal tract is an important question that must be answered as soon as possible.

Adenocarcinoma of the lower oesophagus poses a major therapeutic challenge, only by separating it from squamous cancer will we understand the disease, and in particular its aetiology, better. It is important that we are not diverted by incomplete epidemiological data that may lead us away from the correct conclusion.

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- Coggon D, Inskip H. Is there an epidemic of cancer? *BMJ* 1994;308:705-8. (12 March.)
- Office of Population Censuses and Surveys. *Mortality statistics, cause, 1981-1990*. London: HMSO, 1983-91. (Series DH2, No 8-17.)
- Powell J, McConkey CC. Increasing incidence of adenocarcinoma of the gastric cardia and adjacent sites. *Br J Cancer* 1990;62:440-3.
- Levi F, Ollyo JB, La Vecchia C, Boyle P, Monnier P, Savary M. The consumption of tobacco, alcohol and the risk of adenocarcinoma in Barrett's oesophagus. *Int J Cancer* 1990;45:852-4.
- Yang PC, Davis S. Incidence of cancer of the esophagus in the US by histologic type. *Cancer* 1988;61:612-7.

Oral squamous cell carcinoma

EDITOR,—Iain L Hutchison discusses the problems of screening by general dental and medical practitioners¹ but doesn't mention the opportunity to screen medical patients admitted to hospital. An oral examination should be part of clerking. Indeed, many such patients can be regarded as at risk in that they are commonly elderly and of low socioeconomic class and have disease related to alcohol or tobacco.

A simple oral examination with a wooden spatula and pen torch was carried out on 50 random patients (21 female, 29 male) admitted to the medical wards of a teaching hospital. Only 13 patients could recall an oral examination having been carried out, and in only five cases had any record been made in the notes. Interestingly two

of these patients had been admitted with an oropharyngeal complaint and two had specifically complained about their mouths; the remaining patient had been admitted with HIV infection.

The screening showed various oral conditions, including thrush (six cases), active dental disease (11), benign cystic lesions (two), erythema migrans (one), and an infected wisdom tooth (one). Most importantly, however, six cases of oral ulceration were detected. In four of these the cause seemed to be traumatic, while in one an ulcer of no obvious cause was healing. The remaining ulcer was in the right retromolar area in a man with a history of cancer of the larynx treated with local radiotherapy; further examination showed no overt sinister characteristics, and the patient is currently under review.

Clearly the priority at the time of any medical admission is the cause of that admission, but once the patient is in a stable condition in the ward full clerking by the house officer is undertaken. This should provide the opportunity for simple oral screening of easily visible tissues to detect any oral ulceration that may need review. Better training is needed to ensure that this opportunity is not missed.

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1 Hutchison IL. Improving the poor prognosis of oral squamous cell carcinoma. *BMJ* 1994;308:669-70. (12 March.)

Misinterpreted radiograph

EDITOR,—I am amazed that the barium swallow reported by Duncan McCrae was misinterpreted.¹ The film published clearly shows the patient's hand holding the cup of barium at an angle projected over the much narrower oesophagus, the cup not having been discarded on a ledge between the beam and the film (as McCrae would have us believe). Assuming that the radiologist did not make the error of interpreting the cup as a foreign body responsible for the patient's recurrent episodes of acute total dysphagia, the Royal Liverpool University Hospital should instigate an inquiry into why the radiologist's report was not considered and who was responsible for the misdiagnosis.

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1 McCrae D. Minerva. *BMJ* 1994;308:1178. (30 April.)

Confusing photographs

EDITOR,—The legend to the photograph in C M S Royston and colleagues' article on training in laparoscopy highlights an increase in the incidence of damage to the common bile duct since the advent of minimally invasive surgery.¹ If, as the photograph suggests, trainees are now being taught to look for the gall bladder in the pelvis rather than the right hypochondrium, is this really surprising? Is even the *BMJ*'s photo library underfunded? Or have the editors just forgotten their anatomy?

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1 Royston CMS, Lansdown MRJ, Brough WA. Teaching laparoscopic surgery: the need for guidelines. *BMJ* 1994;308:1023-5. (16 April.)

BMJ's English confuses readers

EDITOR,—I was amazed by the title of a recent editorial, which implied that overdose could be treated with calcium channel blockers.¹ I was reassured, however, to read that overdose of calcium channel blockers was being discussed, rather than treatment of overdoses of other drugs with calcium channel blockers. In the same issue Tony Smith mentions *extraversion* instead of *extroversion*² and Bernard Dixon wrote, as the first word of his article, *it's*—meaning *it is*—when he meant *it has*.³ T R Wiggins, who wrote of recovery from near drowning, was let off the hook when "I found *me* head above water," only to succumb to "*rigours* and generalised myarthralgia."⁴ Even Minerva, who is usually precise and efficient in her use of English, managed "treatment with a *cyclovir*" and then sent me scurrying to my dictionary to find the meaning of *coruscating*.⁵ In the same issue are some long, unpunctuated sentences. Try reading aloud Smith's "Women are under represented in politics and the top flights of business despite generations of effort to eliminate prejudice and despite a handful of notable exceptions who have become women prime ministers," or Wiggins' "what did impress me apart from the emetic and laxative effects of saline and adrenaline were the rigours and generalised myarthralgia that we both experienced afterwards."

The *BMJ* is probably the premier medical journal in the English language published in Britain. The issue I quote from contained other errors. English should be a live language not constrained by rigid adherence to fussy rules, but in the *BMJ* the English should be accurate and understandable, and obscure words should be avoided.

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- 1 Kenny J. Treating overdose with calcium channel blockers. *BMJ* 1994;308:1046. (16 April.)
- 2 Smith T. Sex and ambition. *BMJ* 1994;308:1046. (16 April.)
- 3 Dixon B. Bacteria and newsprint. *BMJ* 1994;308:1046. (16 April.)
- 4 Wiggins TR. So nearly a disaster. *BMJ* 1994;308:1047. (16 April.)
- 5 Minerva. *BMJ* 1994;308:1050. (16 April.)

*"Good prose," said George Orwell, "is like a window pane." We agree entirely with Orwell, and that is what we try to achieve in the *BMJ*. Sometimes we fall short, and Dr Smith is right to chastise us. Although we might dispute some of his points, we accept the spirit of his letter and will try still harder.—ED, *BMJ*

Hospitals and benefactors

EDITOR,—The anguish felt by benefactors when their gift is apparently spurned is understandable, but it would be disastrous if potential benefactors were discouraged by the current furore about funding hospital building in south London.¹ Charitable money has become essential to services and research.

People like to see something for their money; thus equipment is easy to fund, especially if it has to do with hearts, children, or cancer. Public collections for the construction of buildings have a long history, as inscriptions on many hospitals testify. What is difficult is to get money in a form that is easily used.

Accepting donations is not simple: there has long been tension among those who wish to give, those who wish to receive, and those who will be left with the consequences. As soon as donated equipment arrives it requires staff and running

costs; when it has proved its worth it will eventually need replacing. Time and again, hospitals fail to plan for this. We try to insist on a business plan before accepting donations, but, with the continual changes in the priorities of purchasers and the siting of services as well as the high turnover of administrative staff with differing goals, donations tied to specific purposes will almost inevitably fall foul of the vagaries of the system from time to time.

What services, teaching, and research need in hospitals and universities is uncommitted money. The trend towards project oriented research may suggest good value for money, but most advances arise serendipitously. Novel findings require a change of course in the middle of a project, and the doctrine of "*cy pres*" (using money for a purpose as near as possible to the original one) recognised in law does not go down well with grant giving bodies. Programme grants are hard to find, and the result of the present straitjacket can be seen at scientific meetings: the obvious questions are answered, but innovative communications are rare.

We need benefactors to concentrate on people rather than equipment and buildings. Four fifths of the costs of providing health care are attributable to staff, but a fraction of donations goes towards employing staff. The government could help by relaxing the squeeze on the dual support system: donors are discouraged by the need for universities to demand ever increasing proportions of salaries as overhead costs. If donors knew that their support to an institution would be used entirely for services and research they would not feel constrained to make it so difficult to use effectively. The fallacy of believing that this can be done by donating equipment or buildings is clearly shown by the current imbroglio.

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1 Dyer O. Charities demand money back in Guy's changoover. *BMJ* 1994;308:935.

General Medical Council

Is under threat

EDITOR,—The independence of the General Medical Council is under threat from the government.¹ The Department of Health has set up several committees to monitor the education and performance of doctors, which were previously—and should be—the sole preserve of the council. Rumours suggest that the government plans to split the council into Scottish, Welsh, Irish, and English divisions and to assume the role of coordinator, which in effect means that it would take full control of the council. Doctors need to protect the council from such measures.

But the council has become stagnant, and there is widespread discontent over its performance. Radical reforms are needed to make it a strong organisation accountable to the profession and the public. I have two suggestions.

Firstly, a person should not be allowed to serve as a member for more than two consecutive terms. The royal colleges and universities have persisted in choosing the same people, who are unwilling to see change, as their representatives to the General Medical Council. They need to be replaced by people who could bring about change. Moreover, the president should always be an elected member. The president has never been a woman or a doctor from overseas. This suggests discrimination on grounds of sex and race and needs to be set right.

Secondly, the council should state clearly that long hours of work are detrimental to the edu-