underlying diseased subcutaneous tissues.² This flap should be replaced when a healthy bed has been obtained, providing improved cover and reduced deformity. This technique was used in one of three patients, with a considerably improved cosmetic result.³ The vascularity of the skin of the head and neck facilitates this approach, but it should be considered when necrotising fasciitis occurs at other sites.

H COX
Senior registrar
J A S CARRUTH
Consultant ear, nose, and throat surgeon
Southampton General Hospital,
Southampton SO9 4XY

S RHYS WILLIAMS
Consultant ear, nose, and throat surgeon
Poole General Hospital,
Poole BH15 2JB

A P BRIGHTWELL
Consultant ear, nose, and throat surgeon
Royal Devon and Exeter Hospital,
Exeter EX2 5DW

- 1 Burge TS, Watson JD. Necrotising fasciitis. *BMJ* 1994;308:1453-4. (4 June.)
- 2 Stamenkovic IV, Lew PD. Early recognition of potentially fatal necrotising fasciitis. The use of frozen section biopsy. *N Engl J Med* 1984;308:1689-93.
- 3 Rhys Williams S, Carruth JAS, Brightwell AP. Necrotising fasciitis of the face without significant trauma. *Clin Otolaryngol* 1992;17:344-50.

Teaching laparoscopic surgery

Role of government centres

EDITOR,—C M S Royston and colleagues find it hard to discern a role for "the centres for minimally invasive surgery" that "the government is setting up."¹ I hope that I can help them. The centres in London and Leeds have been funded jointly by the NHS Executive and the Wolfson Foundation as minimal access therapy training units. Government funding for the centre in Dundee comes from the Scottish Office. The centre's function is to design, validate, and encourage training of high quality across the whole range of minimal access surgery, of which laparoscopic surgery is one component.

The physical arrangements for the minimal access surgery training unit at the Royal College of Surgeons of England are now almost complete. We will have well equipped skills workshops at the college, with audiovisual links initially with the Royal London Hospital (the Royal Hospitals NHS Trust) and the Royal Surrey County Hospital Trust, Guildford. Links with other clinical centres will follow soon.

We have a strategy for developing courses. Firstly, the objectives, curriculum, and means of teaching and assessing each module will be worked out by a team of experts. Course material will then be generated, the course will be piloted at the college, and a faculty of trainers will be identified and trained at the college. Finally, the course will be made available to other centres, as has happened with the highly successful advanced trauma life support course.

Our first course, on basic skills for safe laparoscopic surgery, was piloted in June. A training course for trainers had been held in May and was the first of what will be a series of such courses.

The team that developed the basic skills course comprises surgeons and gynaecologists selected for their experience in running courses in laparoscopic surgery. For more advanced courses the minimal access therapy training unit will need to work with specialist associations to initiate courses that will fit the curriculums now being developed by the special advisory committees for higher surgical training. Indeed, minimal access techniques may well form an important part of more wide ranging courses that the associations may wish to develop with the newly established Raven department of education at the Royal College of Surgeons of

England. If we are to recognise trainers to act as proctors this surely must be done through groups such as the Association of Endoscopic Surgeons of Great Britain and Ireland and the Society for Minimally Invasive Therapy. Thus we are already setting up the sort of training programmes that Royston and colleagues advocate.

In calling for accreditation and compulsory audit Royston and colleagues raise issues that have been fully addressed over the past two years by the four surgical royal colleges and the specialist associations. A major statement on quality assurance has been published by the senate of the royal colleges of Great Britain and Ireland and will soon be distributed to every surgeon in Britain.²

Minimal Access Therapy Training Unit,
Royal College of Surgeons of England,
London WC2A 3PN

CHRIS FOWLER
Tutor

- 1 Royston CMS, Lansdown MRJ, Brough WA. Teaching laparoscopic surgery: the need for guidelines. *BMJ* 1994;308:1023-5. (16 April.)
- 2 Senate of the Royal Colleges of Great Britain and Ireland. *Quality assurance: the role of training, certification, audit and continuing professional education in the maintenance of the highest possible standards of surgical practice*. London: Senate secretariat, Royal College of Surgeons of England, 1994.

Preliminary training on animals is essential

EDITOR,—Paul Byrne deplores the absence of the availability of animal laboratories in the teaching of laparoscopic skills.¹

In Canada, generally accepted as a humane nation, preliminary experience in animals, specifically pigs, which are anaesthetised and destroyed after operation, is mandatory before proceeding to supervised experience with patients, first as an assistant and then as chief operator under the aegis of a qualified licensed preceptor. Privileges are granted for laparoscopic surgery only to those who have successfully completed such a training cascade.

Perhaps the Royal College of Surgeons of England could scrutinise the Canadian system both from the point of changing the law about operating on live animals and as a method of minimising learning curve morbidity caused by unsupervised, self taught surgeons.

GERALD S CLAYDEN
Staff surgeon

Flin Flon General Hospital,
Flin Flon, Manitoba,
Canada RA8 1M8

- 1 Byrne P. Teaching laparoscopic surgery. *BMJ* 1994;308:435. (12 February.)

Breast feeding and multiple sclerosis

EDITOR,—Alfredo Pisacane and colleagues suggest that breast feeding may protect against the development of multiple sclerosis.¹ This provides some support for the "dietary fat hypothesis,"² which posulates that the geographical distribution of multiple sclerosis reflects a relative deficiency of dietary essential fatty acids.³ As breast milk is a rich source of essential fatty acids it may have an effect on cerebral myelination and hence susceptibility in adult life to either viral or autoimmune damage.

The authors' results must be treated with some caution for two reasons. Firstly, two previous studies have failed to show any significant association between breast feeding and multiple sclerosis, but neither measured the duration of breast feeding.^{3,4} In both studies the number of bottle fed children was small and therefore the lack of a significant result may simply reflect a type II error. Secondly, the results may reflect confound-

ing by socioeconomic status, as the authors point out. Breast feeding, at least in Britain, was more common among mothers of manual class in the 1940s,⁵ when the sample would have been babies. As socioeconomic status is a marker for sanitary conditions the authors' results are also compatible with the hypothesis that multiple sclerosis may be the result of delayed exposure to a common infectious agent.

Further studies should attempt to abolish the confounding between breast feeding and social class by choosing specific populations in which the relation between breast feeding and social class is absent or reversed.

YOAV BEN-SHLOMO
Wellcome research fellow

Department of Community Health and General Practice,
Trinity College,
Dublin 2,
Republic of Ireland

GEORGE DAVEY SMITH
Senior lecturer in epidemiology

Department of Public Health,
University of Glasgow,
Glasgow G15 8RZ

- 1 Pisacane A, Impagliazzo N, Russo M, Valiani R, Mandarini A, Florio CV, et al. Breast feeding and multiple sclerosis. *BMJ* 1994;308:1411-2. (28 May.)
- 2 Ben-Shlomo Y, Davey Smith G, Marmot MG. Dietary fat in the epidemiology of multiple sclerosis: has the situation been adequately assessed? *Neuroepidemiology* 1992;11:214-25.
- 3 Berr C, Puel J, Clanet M, Ruidavets JB, Mas JL, Alperovitch A. Risk factors in multiple sclerosis: a population-based case-control study in Hautes-Pyrenees, France. *Acta Neurol Scand* 1989;80:46-50.
- 4 Cendrowski W, Wender M, Dominik W, Flejsierowicz Z, Owsianowski M, Popiel M. Epidemiological study of multiple sclerosis in western Poland. *Eur neurol* 1969;2:90-108.
- 5 Medical Research Council. *Infant nutrition and cardiovascular disease. Proceedings of a meeting held on 29th October 1986 at the MRC Environmental Epidemiology Unit*. Southampton: MRC Environmental Epidemiology Unit, 1987: 1-47.

Legislation on juniors' hours

EDITOR,—In the continuing debate on the regulation of the hours worked by junior doctors¹ attention should be given to the fact that junior doctors form a large and disparate group with differing requirements. Most preregistration and senior house officers in the acute specialties work for most of their time on duty. It is therefore right to provide regulated protection from undue loss of sleep and too prolonged an exposure to clinical responsibilities, which for many are new and demanding.

Doctors who have progressed to career training posts as registrars and senior registrars are a different group. The aim of these doctors is to widen their experience, including their experience of managing emergencies, which offer exceptional opportunities for the development of diagnostic and therapeutic skills and sound judgment. By definition, emergencies present at unpredictable times, and it would be wrong for surgical trainees, for instance, to be prevented from following their patients from the bedside to the theatre because of a limitation on their hours.

For registrars and senior registrars a 24 hour period on call may be busy but may be relatively quiet. It would be a serious mistake to allow a strict measurement of hours spent on call also to represent hours actually worked. Surgical training is already affected by the promotion of day case and minimal access surgery, and senior trainees should be allowed control over their working practices.

In the past, insufficient care was taken to give senior trainees reasonable time off duty, but experience shows that now the danger lies in the opposite direction.² A balanced approach is needed. As soon as these surgeons become consultants they will undertake continuous responsibility for the care of their patients, so it is reasonable for them to prepare for this. How senior trainees and consultants should integrate their work and their free time should be decided by