Computed tomogram in case of perforating injury to right eye.

superotemporal quadrantanopia. There was no sympathetic ophthalmia.

All stab wounds and similar injuries to the eye and orbit should alert the examining doctor to the possibility of intracranial damage. A normal level of consciousness does not exclude intracranial damage—symptoms may not arise for up to two months after the initial event.¹⁻³ Examination must include visual field testing; skull x ray and computed tomography may confirm clinical suspicion.

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- 1 Bard LA, Jarrett WH. Intracranial complications of penetrating orbital injuries. *Arch Ophthalmol* 1964;71:332-43.
- 2 Duffy GP, Bhandari YS. Intracranial complications following transorbital penetrating injuries. *Br J Surg* 1969;56:685-8.
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Leg ulcers

SIR,—Professor H A F Dudley (2 January, p 65), in his criticism of Dr P K Buxton's article (12 December, p 1542), suggests that in up to a quarter of patients with venous ulceration this is the result of isolated saphenofemoral incompetence and that permanent cure of the ulcer can be achieved by saphenofemoral ligation.

This has been well recognised for many years, and true "varicose ulceration" responds well to saphenofemoral ligation and stripping. It was the frequently poor results of this operation that led Cockett and Elgan Jones in 1953¹ to investigate the contribution of perforating vein incompetence to venous ulceration and to coin the term "ankle blow-out syndrome." In limiting the surgery of venous ulceration to patients with isolated saphenofemoral incompetence, Professor Dudley denies the possibility of permanent ulcer healing to those many patients, three quarters of the total in his view, with other venous disorders. Although both Professor Dudley and Dr Buxton fail to mention the lower calf and ankle perforating veins, Dr Buxton does describe the ankle vascular "flare." The importance of this preulcer venous flare was first recognised by Cockett and Elgan Jones, who pointed out that it is a network of thin walled fine venules, not varicose veins, which communicate with one or more perforating veins and dilate when these become incompetent. Professor Dudley

quotes Sethia's and Darke's finding that 17 of their ulcerated legs had primary long saphenous incompetence²; it is also relevant that perforating vein incompetence was shown in 59 of these 60 legs. A lower incidence (14/23; 61%) was found in the study of which Professor Dudley is a coauthor,³ but this is perhaps a result of inadequate investigation, Doppler ultrasound having been used only to investigate saphenofemoral and popliteal incompetence in this study.

In a study of 77 patients with venous ulceration⁴ we used Doppler ultrasound to detect calf and ankle perforating vein incompetence, and this was found in 108 of 109 ulcerated legs, an incidence remarkably similar to that reported by Sethia and Darke. Saphenous incompetence was found in 47% of these patients and deep vein incompetence, as indicated by popliteal reflux detected by Doppler ultrasound, in 41%. All these patients underwent subfascial perforating vein ligation with saphenofemoral ligation and stripping where this was incompetent. Those with evidence of deep vein incompetence wore knee length elastic compression stockings after operation. Early results have been encouraging, over 80% of ulcers remaining healed between three and six years after surgery. A 10 year follow up study is now being organised. Doubtless some of the initially healed legs will have reulcerated, but it seems likely that permanent healing will be achieved in many more than the 25% with isolated saphenofemoral incompetence which Professor Dudley considers suitable for surgery.

The dismal long term results of conservative management by dressings and elastic compression are too well recognised to need repetition. Apart from perforating vein ligation, popliteal reflux can now sometimes be corrected by axillary vein transposition, and surgery offers the possibility of long term ulcer healing to many more patients than those with isolated saphenofemoral incompetence.

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- 1 Cockett FB, Jones DEE. The ankle blow-out syndrome. A new approach to the varicose ulcer problem. *Lancet* 1953;ii:17-23.
- 2 Sethia KK, Darke SG. Long saphenous incompetence as a cause of venous ulceration. *Br J Surg* 1984;71:754-5.
- 3 Hoare MC, Nicolaides AN, Miles CR, *et al*. The role of primary varicose veins in venous ulceration. *Surgery* 1982;92:450-3.
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SIR,—Professor H A F Dudley (2 January, p 65) suggests that surgical treatment of long saphenous incompetence might relieve varicosities leading to leg ulcers in about 25% of patients. If so I am sure this would be welcomed by both the sufferers from venous ulcers and those who care for them.

Sethia and Darke give the average age of the patients studied as 55.4¹ but most patients in the dermatology clinic with leg ulcers are considerably older than this.² I was unable to find the article by Hoare *et al* as the reference was incorrectly printed. It would seem, however, that the results were basically the same.

Other authors suggest that primary saphenous insufficiency is relatively rarely associated with venous ulcers.³⁻⁵

Another problem is determining the relative roles of long saphenous incompetence and incompetent perforating veins lower in the leg, but the techniques mentioned by Professor Dudley should help to elucidate this.

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- 1 Sethia KK, Darke SG. Long saphenous incompetence as a cause of venous ulceration. *Br J Surg* 1984;71:754-5.

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Vitamins and neural tube defects

SIR,—Professor Rodney Harris (9 January, p 80) omitted to mention the study conducted on behalf of the Committee on Safety of Medicines by Winship *et al*.¹

Babies born with neural tube defects were identified by the Office of Population Censuses and Surveys. Prescription data for the three months before the last menstrual period and for the first trimester of pregnancy were obtained for 764 mothers whose children had a defect of the central nervous system and for an equal number of mothers of control babies born from the same doctors' practices.

There was a statistically significant difference overall between the numbers of mothers who were prescribed drugs in the study and control groups during the three months before the last menstrual period but no such difference was found for the first trimester of pregnancy, nor was there a significant difference for any specific group of drugs. For a composite group of non-steroidal anti-inflammatory drugs, salicylates, and sulphasalazine there was a significant difference for the trimester before the last menstrual period. There are arguments against such an artificial grouping, however, and when the individual drugs were considered the comparisons were no longer significant. The odds ratios for all medicines containing folic acid taken in the trimester before the last menstrual period were considerably less than unity, in contrast with nearly all other comparisons. This supports a suggested protective effect against neural tube defects of folic acid supplements begun before the onset of pregnancy.

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- 1 Winship KA, Cahal DA, Weber JCP, Griffin JP. Maternal drug histories and central nervous system anomalies. *Arch Dis Child* 1984;59:1052-60.

Sexism and the plural in medical writing

SIR,—Consistent use of the plural, Sue Burkhardt's solution to continuing male arrogance in medical writing (19-26 December, p 1585), would achieve more than this.

How deceptively easy and usually irrelevant it is for the doctor to attain clinical and ethical "excellence" for the patient; how difficult and relevant it is for all doctors to do their best for all the people they serve. Doctors who carelessly omit half the human race because they are women would write more accurately by using the plural, but they might also begin to see many others in their catchment area who "realistically" must be forgotten. By thinking in group terms medical authors will be encouraged to accept more generally the real test of quality and relevance in work they describe, the relation of their acts and observations as numerators over at least an implied population denominator; not only that such and such can now be done but whether or not it is actually being done on more than a token scale.

We may not be personally responsible for the increasing non-application of advances in medical

science, but we make ourselves so when our writing concentrates attention on singular cases rather than plural obligations. When doctors are being invited to maintain excellence by selling it to a few while ignoring the needs of the population as a whole this would be a timely and useful development. We can look forward to an even better journal when this rule has become generally accepted.

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SIR,—I wholeheartedly endorse Sue Burkhart's statement that medical writing needs exact and unambiguous language (19-26 December, p 1585); I suggest that "direct" and "jargon free" could usefully be added to the list of requirements.

The problems inherent in presenting ideas, observations, and information from one person to a wider readership are numerous and need to be understood by all concerned: authors, publishers, and readers. Publishers form the group with the greatest responsibility for establishing acceptable workable solutions and for taking a creative and flexible approach as the use of language changes among the reading population. Publishers are well placed to work with writers in finding the most appropriate solutions and they should also make it clear to readers which solution has been adopted.

Ms Burkhart referred to one of the books we have recently published and to the solution to the problem of using male and female pronouns which I established and agreed with the author,¹ and *BMJ* readers may be interested in the reasons for this decision. The author had originally used the more cumbersome "his or hers" and "he or she." We both felt that we could not assume that readers would automatically read "he" to include both men and women and that random use of different pronouns would simply confuse. We agreed that the use of both was cumbersome and would distract the reader from the ideas and discussion. The option which Sue Burkhart suggests, of using the plural, was not open to us either because the subject, caring for dying people, involved a sensitive and often intimate level of communication between carer and cared for, and the use of the plural would have distanced the author from the subject and implied an unwelcome distance between carer and patient, one of the particular problems which the author was trying to support the reader to overcome. We decided that the least cumbersome and most workable solution was to use female pronouns for nurses of both sexes and male pronouns for patients of both sexes, except where a specific example demanded otherwise and to inform our readers of this convention at the start of the book. Given that about 90% of nurses in Britain are women,² this seemed a reasonable, pragmatic solution. This is the solution we have adopted for the time being as our house style for books and for the journal *The Professional Nurse*.

Authors, publishers, and readers need to accept that there are no perfect solutions to the problem of sexism within our language and remain open to the need for different solutions at different times and for different purposes. What matters most is that the author's ideas are made available to readers as clearly, directly, and accurately as possible.

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1 Neuberger J. *Caring for dying people of different faiths*. London: Austen Cornish Publishers Ltd in association with the Lisa Sainsbury Foundation, 1987:vi.

2 United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *Annual Report 1985-1986*. London:UKCC, 1987.

Major abdominal operations on elderly patients

SIR,—As a physician involved in medical pre-operative assessment of surgical patients, I find the results reported by Mr A V Pollock and Miss Mary Evans (12 December, p 1522) disturbing.

It seems misleading to draw comparative conclusions about mortality rates and complication rates of abdominal surgery in the over 80 age group when 77% of the operations were done on an emergency or urgent basis and 43% were for cancer. Furthermore, the authors compare this group with a younger age group but give no indication whether or not surgery was carried out on an emergency basis or for cancer in this group. In most reports the causes of abdominal emergencies in patients over 70 are entirely different from those in a younger age group.¹

There is evidence to suggest that surgery among those aged over 80 is safe and that age related risk seems to increase only in those aged over 95.^{2,3} Indeed, centenarians ("as close to immortality as a human can be") generally tolerate even urgent operations well.⁴ Other groups report a declining mortality for emergency abdominal procedures in geriatric patients (12% in one series of 472 emergency operations) but not in patients with advanced malignancy.¹

Increased awareness of the relative safety of elective surgery in elderly patients may make physicians more willing to operate on an elective basis and thus reduce the number of elderly patients for whom emergency surgery (and its considerable mortality) is necessary. The rationale for postponing elective surgery in the elderly seems questionable if this seemingly unnecessary mortality is to be avoided.³ Surgery should not be denied in the elderly on the basis of age alone.^{5,6}

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1 Reiss R, Deutsch AA. Emergency abdominal procedures in patients above 70. *J Gerontol* 1985;40:154-8.

2 Djokovic JL, Hedley-Whyte J. Prediction of outcome of surgery and anaesthesia in patients over 80. *JAMA* 1979;242:2301-6.

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Pain in the jungle

SIR,—One lesson which emerges clearly from Dr Jane Wilson's vivid account of the effects of a scorpion sting (19-26 December, p 1642) is that morphine in tablet form is quite the wrong choice of strong analgesic for dealing with severe acute pain, whether it be in the jungle or anywhere else.

Single doses of morphine by mouth have poor analgesic activity: Dr Wilson would have gained more relief from two aspirins.¹ This surprising fact has tended to be forgotten as oral morphine has become the preferred strong opioid analgesic for the treatment of chronic cancer pain. Morphine in repeated oral doses is more potent, and the explanation for the difference may reside in the contribution of one or more active metabolites.² Dr Wilson's somnolence the day after several doses of morphine may have been because morphine-6-glucuronide was still active in her central nervous system.

For her next expedition to the jungle I would suggest Dr Wilson take some buprenorphine

tablets. Buprenorphine is a potent opioid analgesic and for the treatment of acute pain is almost as effective taken sublingually as by intramuscular injection.³

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1 Beecher HK, Keats AS, Mosteller F, Lasagna L. The effectiveness of oral analgesics (morphine, codeine, acetylsalicylic acid) and the problem of placebo "reactors" and "non-reactors." *J Pharmacol Exp Ther* 1953;109:393-400.

2 Hanks GW, Hoskin PJ, Aherne GW, Turner P, Poulain P. Explanation for potency of repeated oral doses of morphine? *Lancet* 1987;ii:723-5.

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Charging patients for eye tests

SIR,—The present controversy about free eye testing should be used as a golden opportunity for reform. It should not be used as a stick with which to beat the government, as an opportunity for putting opticians into their (non-medical) place, or as a defence of the rather undignified position of the ophthalmic medical practitioner.

The ophthalmic medical practitioner is a trained clinical ophthalmologist expert in the detection of eye disease. Yet, working as he sometimes does in the ill equipped back room of an optician's shop, he does not have the opportunity of using his talents to the full. The optician is also a highly trained professional but with minimal education in eye disease is not a suitable person to carry out screening without supervision and instruction. The financial rewards of the ophthalmic medical practitioner depend on throughput and of the optician on sales.

The skill and manpower for an efficient ophthalmic screening programme are therefore available within a malleable financial framework. It should thus not be beyond the wit of man to devise a programme for screening large sections of the population, not by extra funding but by making good use of existing skills. Such a programme would enhance the status of the ophthalmic medical practitioner, increase the importance of the optician, and be for the public good.

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Anaesthetic services in obstetrics

SIR,—The Association of Anaesthetists has recently published *Anaesthetic Services for Obstetrics—a Plan for the Future*.¹ This mainly consists of defamations of small obstetric units. The association recommends that "small units which offer a substandard level of anaesthetic service should be closed" on the grounds of safety, yet nowhere in the report is there any evidence that closure of such units would improve safety.

The report states that some 8-10 women die in England and Wales each year as a result of anaesthetic complications and that the perinatal mortality rate in 1985 was 9.8 per 1000 births. It also states that only 1% of deliveries take place in very small units (those having under 500 deliveries per year). It is hard to see how their closure would have any impact on mortality unless the units result in an undue proportion of deaths. Several authors have shown quite the contrary.^{2,4} Such units can show very low perinatal mortality (as one would expect with good selection). The perinatal