outpatient physical examination. Even with the increasing excellence of the fiberoptic instruments and their increasing use in both inpatients and outpatients it would seem inappropriate at the moment to regard rigid sigmoidoscopy as being anything other than the first and essential investigation.

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SIR,—The traditional role of barium radiology is being increasingly challenged by endoscopists. The article by Dr D C Lindsay and colleagues (16 January, p 167) is fairly typical of most reports from endoscopists. Cooperative studies by radiologists and endoscopists usually give a more balanced view. The authors set off on the wrong foot by stating that fiberoptic gastroduodenoscopy is now accepted as the first investigation for the vast majority of patients with upper gastrointestinal symptoms. There is considerable evidence to the contrary.^{1,5}

For the large bowel the barium enema examination is capable of an accuracy not far below that of total colonoscopy.⁶ Also radiology is safer and more likely to give a complete examination. Dr Lindsay and colleagues are wrong to imply that because no major complications occurred in their 168 patients the two techniques are equally safe. The list of complications associated with colonoscopy is long and impressive. Quoted mortality rates from simple diagnostic colonoscopy range from 0.03%⁷ to 0.008%.⁸ If all the 250 000 patients having a barium enema examination this year in England and Wales were to have a colonoscopy instead up to 75 deaths could be expected. Also the authors use the word "completeness" in an unusual way and this is confusing. Barium enema is complete to the caecum in virtually all patients whereas colonoscopy is incomplete in about 25%. Having a substantial proportion of patients with an unexamined caecum and ascending colon obviously limits the value of the technique. As a general policy there is much to be said for continuing to use the double contrast barium enema examination as the initial examination (supplemented when necessary by fiberoptic sigmoidoscopy), except when biopsy or polypectomy may be indicated or in those patients in whom the advantage of the potentially greater accuracy of colonoscopy outweighs the extra risk and high incidence of incomplete examination.

Spurred on by the pharmaceutical and optical industries, and with opportunities for self referral, the endoscopy bandwagon is on the move. But the replacement of barium radiology to an extent advocated by endoscopists like Dr Lindsay and colleagues would be expensive, inappropriate, and unnecessary. Radiology is already in place and providing a good service. Therefore it makes both clinical and financial sense for endoscopy to complement and not replace barium studies. Further expansion of the endoscopy service should be concentrated on those areas where a suitable alternative is not so readily available.

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Skin reactions and fever with indapamide

SIR,—Dr B H Ch Stricker and Mr C Biriell (21 November, p 1313) seemed to write their article out of concern that there existed no published case reports of skin reactions with indapamide and because a "frequently reported" phenomenon does not appear in the British and Dutch data-sheets. It was unfortunate that they did not follow the *BMJ* guidelines established for this type of report¹ and contact the manufacturers before submitting their article; this would have allowed us to provide them with information they appear to lack, to express our reservations about their analysis and interpretation of the data presented, and to question the relevance of the article itself.

In analysing the data the authors compared the incidence of skin reactions expressed as a percentage of the total number of adverse reactions for the different diuretics considered. Such comparisons are, however, of questionable meaning as the percentage for any one effect depends entirely on the magnitude of the total number of effects. Thus to observe that in the Netherlands database 36% of all recorded reactions to indapamide were skin reactions compared with only 17% of those to chlorthalidone gives a somewhat distorted picture of the comparable absolute numbers of cases: 16 and 15 respectively.

Furthermore, the authors comment on these and the World Health Organisation data by stating that comparisons of suspected adverse reactions to indapamide, chlorthalidone, hydrochlorothiazide, and frusemide showed a high prevalence of rashes with indapamide. While they express reservations about interpreting data based on voluntary reports, it is nevertheless relevant that the absolute incidence of skin reactions reported with indapamide is less than two thirds of that for hydrochlorothiazide and less than one third of that for frusemide.

While mild rashes are known to occur with indapamide,^{2,6} which is not entirely surprising for a compound chemically related to the sulphonamides, their importance must be placed in proper context. Servier has over 10 years of worldwide experience with indapamide: over 100 million one month packs have been sold, and 1.5 million patients are treated with indapamide every day. Adverse effects have always been rare and mild and this is particularly true for skin reactions, which usually do not require specific treatment and resolve rapidly when the drug is discontinued.

Indeed, with only 188 reports of skin reactions associated with indapamide since it was released on to the market in 1975, the World Health Organisation data corroborate our own experience. And if these cases account for a higher than average proportion of the total number of adverse reactions this is less suggestive of a "high prevalence" of skin reactions than a testimony to the low overall incidence of adverse effects and to the excellent acceptability of the product.

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Severe open fractures of the tibia

SIR,—Surgeons like to be courageous and we are concerned lest Mr F W Heatley's leading article (23 January, p 229) calling for "the courage to amputate" unnecessarily increases the population of one legged ex-motorcyclists.

There will always be compound tibial fractures for which primary amputation is appropriate. Equally there will continue to be cases where the decision is less clear cut (no pun intended). It is overly pessimistic, though, simply to suggest that Caudle and Stern's report¹ of the outcome of type III fractures "should stimulate us to redefine the place of primary amputation." More attention should be paid to ways of improving the outcome, and important clues are present in the subdivision by Caudle and Stern of patients with type IIIB fractures into those with early restoration of soft tissue cover and those without. The former had lower rates of non-union (23% v 77%), infection (8% v 59%), and secondary amputation (8% v 24%) than the latter. It is disappointing that this should have been ignored by Mr Heatley, who bemoans the lack of relevant subgroups in "most published reports."

There is good evidence that the incidence of infection and non-union (the factors most frequently responsible for a poor outcome in compound fractures) is reduced by thorough wound debridement and early cover of the bone with healthy soft tissues.^{2,3} Though external fixation improves access to the wound a surgeon unfamiliar with modern plastic surgical techniques may still be insufficiently radical in his debridement and leave the wound to heal by secondary intention. (He may also unwittingly sabotage potential reconstructive procedures by injudicious placement of the fixator or additional incisions.) Bone or periosteum which is left exposed desiccates and dies despite attempts to prevent this. The presence of dubiously viable tissue and inevitably infected granulation completes the recipe for osteomyelitis. In contrast, early flap cover prevents desiccation and improves local blood supply, providing a more favourable environment for bone healing and allowing the preservation of devascularised but otherwise healthy bone fragments as free grafts.

We believe that wider adoption of the philosophy of early combined management proposed by the late Marko Godina (and others) would improve the outlook for patients with these difficult injuries. In his series of 532 patients with complex trauma of the extremities those undergoing reconstruction within 72 hours had a lower infection rate (1.5% v 17.5%), fewer anaesthetics (1.3 v 4.1), and shorter average bone healing time (6.8 v 12.3 months) and spent less time in hospital (27 v 130 days) than those undergoing delayed reconstruction.³

Immediate assessment by both an orthopaedic and a plastic surgeon allows decisions for or against primary amputation to be made in full light of