Points

Aspirin megatrials

Professor J P VANDENBROUCKE (Department of Clinical Epidemiology, University Hospital, 2300 RC Leiden, The Netherlands) writes: Perhaps the most important lesson from the recent avalanche of anti-platelet megatrials is the following quote from the UK-TIA Study Group: "Having spent nearly 10 years designing, funding, conducting, and analysing this study, we are frustrated to conclude that its results cannot stand alone" (30 January, p 316). The solution proposed is a meta-analysis. It might be time, however, to acknowledge that medicine is more than just a numbers game: physiology, biochemistry, and clinical science are also necessary. Moreover, professional philosophers of science have already backed away from the idea that "crucial experiments" exist; the discrepant results between the United States and the United Kingdom primary aspirin prevention trials, at least for fatal myocardial infarction, seem to offer these philosophers empirical support. Some modesty about the claims for the superior role of clinical megatrials in medicine might result from the aspirin experience.

Dietary management of gastroenteritis in Britain

Dr R J WILSON (Tavistock, Devon PL19 8BG) writes: Oral rehydration with sugar and salt added to water is good for replacing lost fluid, but, much more important, it reduces fluid lost by diarrhoea—hence it is easy to persuade parents to use it. The sugar and salt are actively absorbed and osmotically draw the water, so emptying the bowel and filling the rest of the child. This is a simple principle to explain and helps compliance. Though I use made up powders for young children because they contain potassium, "home made" solutions need not be inaccurate and are useful for the older members of the family who may also want to reduce the volume of their diarrhoea. The World Health Organisation recommends an easy formula: "Level 5 ml spoonfuls: eight of sugar and only one of salt in one litre—that is, 2 pints—of water."

Should colonoscopy be the first investigation for colonic disease?

Messrs J RAWLINSON, F P MCGINN, and F J BRUNTON (Departments of Radiodiagnosis and Surgery, Southampton General Hospital, Southampton) write: Dr D C Lindsay and others (16 January, p 167) suggest that "where facilities allow" colonoscopy should be the first investigation for suspected colonic disease. Few centres have the facilities, and even if they did we question the wisdom of adopting such a policy. In the Southampton district about 2000 patients had a barium enema examination and 1000 a colonoscopy during 1987. The waiting list for urgent cases is two to three weeks for either examination. For non-urgent cases the wait is two and three months for barium enema examination and colonoscopy, respectively. To investigate all patients by endoscopy first would require a massive injection of resources to create the facilities and acquire the skill. Southampton is among the 11% of districts in Britain which do more than 400 colonoscopies each year.¹ Resources may be even more limited elsewhere.

1 Axon ATR, Bottrill PM, Campbell D. Results of a questionnaire concerning the staffing and administration of endoscopy in England and Wales. *Gut* 1987;28:1527-30.

Advice on contraceptive services for ethnic minorities

Drs BRIAN R MCAVOY and RABIA RAZA (Department of Community Medicine, University of Leicester, Leicester LE2 7LX) write: Dr Jon Fuller's article (29 November 1987, p 1365) and subsequent correspondence (23 January, p 293, and 27 February, p 642) raise the issue of patients' preferences. Dr Fuller quoted our paper to support his view that "patients should be offered a choice of counsellor which reflects

the ethnic make up of a community." In fact our survey of a random sample of Asian women in Leicester aged 16 to 50 showed clearly expressed preferences for language and gender but not for ethnic background.¹ Of those who had used contraception at some time, 73% stated that when they had wanted information about family planning they had been able to get it as easily as they had wished, with only 6% disagreeing; 55% preferred to discuss birth control in their mother tongue, 35% in English, and 10% said it did not matter. When asked about the gender of the doctor providing contraceptive advice 83% preferred a woman, 3% a man, and 14% had no preference. In contrast, 55% expressed no preference on the ethnic background of the doctor, 27% preferred a non-Asian, and 22% preferred an Asian. Preferences for language, gender, and ethnic background of doctors were similar in Hindus, Moslems, and Sikhs.

1 McAvoy BR, Raza R. Asian women: (ii) contraceptive services and cervical cytology. *Health Trends* 1988;20:14-7.

Special footwear

Dr R G S PLATTS (Royal National Orthopaedic Hospital, Stanmore, Middlesex HA7 4LP) writes: Dr E G White (20 February, p 548) quotes Sheila Bainbridge's survey of NHS surgical footwear¹ and says that it "showed a high level of patient satisfaction with 82% satisfied or highly satisfied overall." This means that nearly one patient in five is dissatisfied and conceals several more disquieting findings. For example, 22% of women aged 65 and over were dissatisfied or very dissatisfied with their surgical footwear. In the 15 to 39 year age group 30% of women were dissatisfied. The survey says that "while 18% of footwear users actually complained, a further 9% said they had felt like making a complaint but hadn't actually done so." More than one in four were dissatisfied, which can hardly be described as a high level of satisfaction.

1 Bainbridge S. *National Health surgical footwear—a study of patient satisfaction*. London: HMSO, 1979.

Financial deprivation in the NHS

Dr PHILIP ROBERTS (Norfolk and Norwich Hospital, Norwich NR1 3SR) writes: On behalf of the Norwich district consultant staff committee I welcome Dr Tony Smith's leading article (2 January, p 1) but want to point out that peripheral, RAWP recipient hospitals such as those in Norwich have been hit just as hard as the London and metropolitan hospitals. In Norwich Health Authority's short term programme, over the next two years, we shall experience a real fall in income of 0.1% a year in funding the acute hospital sector, five long needed additional consultant posts have been frozen, and we currently have an unfunded £17m backlog of maintenance work on buildings. We already start from a relatively lower level of funding and provision of health care facilities than in many of the metropolitan hospitals. Our problems are related principally to underfunding of revenue to keep pace with previous shortages and deficiencies, to meet underfunded pay awards, and to meet with current demographic and technological change. We can see no immediate prospect of ameliorating this debilitating situation.

Secretor state of patients with diabetes mellitus

Drs P-J LAMEY, T W MACFARLANE, and L P SAMARANAYAKE (Department of Oral Medicine and Pathology, Glasgow Dental Hospital and School, Glasgow G2 3JZ) write: Dr C C Blackwell (30 January, p 357) questions the source of our control patients (12 December, p 1563). These patients were not, as she presumes, attending the department of oral medicine and pathology but were attending the department of prosthodontics for construction of dentures. The patients had no oral complaints and had a normal oral mucosa on examination. We conclude again, therefore, that our study failed to confirm the results of Dr Blackwell and colleagues (24 October, p 1024) and that this difference cannot be explained by choice of control subjects. Furthermore, although the trend in

both our study and that of others¹ has shown a tendency to higher non-secretor rates in insulin dependent diabetics, this was found to be not statistically significant.

1 Peters WH, Gohher W. ABH-secretion and Lewis red cell groups in diabetic and normal subjects from Ethiopia. *Exp Clin Endocrinol* 1986;88:64-70.

Clumsy children

Messrs K PEARMAN, P M SHENOI, and M G WATSON (Department of Otolaryngology and Oral Surgery, East Birmingham Hospital, Birmingham 9) write: Dr D H B Hall (6 February, p 375) does not mention that clumsiness is occasionally mentioned by parents of children suffering from otitis media with effusion. Treatment by grommet insertion may lead to resolution of the symptom. The complaint is usually of falling easily and bumping into things rather than specific disability with motor tasks. The cause of balance problems in what is usually regarded as a purely middle ear condition is uncertain. Vertigo in otitis media is described briefly in most standard textbooks about the ear, and adults with respiratory infections and eustachian tube dysfunction complain occasionally of balance problems. Glue ear is probably not a major cause of clumsiness but its detection and treatment may help in some cases.

Upper gastrointestinal Kaposi's sarcoma in patients positive for HIV antibody

Dr CHRISTOPHER P CONLON (Department of Medicine, University Teaching Hospital, Lusaka, Zambia) writes: Dr I G Barrison and others (9 January, p 92) suggest that patients seropositive for human immunodeficiency virus (HIV) antibodies who have abdominal symptoms may often have gastrointestinal Kaposi's sarcoma in the absence of any cutaneous lesions of Kaposi's sarcoma. At the University Teaching Hospital in Lusaka I have performed upper gastrointestinal endoscopy, using an Olympus GIF XQ10 fully immersible endoscope, on 40 patients seropositive for HIV. Most of these patients had either chronic diarrhoea of small bowel origin or abdominal pain and significant weight loss (more than 10% of body mass), and only three patients had cutaneous lesions of Kaposi's sarcoma. Gastrointestinal lesions suggestive of Kaposi's sarcoma were seen in only two patients, both of whom had cutaneous lesions. Five patients had oesophageal candidiasis and the remainder of the examinations were macroscopically normal. These findings suggest that either African Kaposi's sarcoma rarely affects the gut or, if it does, it rarely causes symptoms. It will be of interest to see how many Zambian patients with cutaneous lesions have gastrointestinal Kaposi's sarcoma.

Use of the word "abortion"

Dr R A A R LAWRENCE (Leabrooks, Derby DE55 1LU) writes: Abortion was discussed during a recent phone in programme on BBC Radio Derby. A number of women listeners expressed their objection to the term "abortion" when it referred to the spontaneous event. They were unanimous in their wish that the term "miscarriage" should be used instead. They felt that abortion should be reserved for those cases where the termination of the pregnancy was deliberately planned. Those who telephoned felt that the medical profession should be aware of the implications in the lay mind when the term abortion is used. Doctors are accustomed to describing an abortion as spontaneous, complete, incomplete, missed, or therapeutic rather than using the word miscarriage. I was involved in the discussion as press secretary and spokesman for the Derby Division of the BMA and I undertook to bring this matter to the attention of the profession. We must remember that access to medical records will become commonplace and the way in which we record our findings will be exposed to the full glare of publicity. Our use of medical terminology should take account of the fact that what may be accurate medically could cause distress to the lay person because of ambiguous interpretation.