	Had agreed to necropsy (n=19)	Had refused necropsy (n=10)
Satisfied with arrangements for handling the baby	18/19	9/10
Found meeting with the doctor seeking consent helpful	14/16	2/4
Counselled about usefulness of necropsy	9/16	3/7
Counselled about necropsy procedure	8/16	1/7
Advised about possibility of limited necropsy		0/8
Advised of availability of report in plain language	16/18	
Satisfied with presentation of necropsy findings	8/16	
Regretted decision to agree or refuse necropsy	1/18	3/10

The number of women who claimed that they had not been informed of what the necropsy entailed or of its usefulness is alarming since it suggests that decisions to consent to or refuse a request for a necropsy are not made after informed counselling. For example, one woman who had agreed to a necropsy assumed that the procedure was only "tissue sampling" and thought that the questionnaire was not applicable to her. There was an apparent lack of knowledge of a limited necropsy; possibly clinicians and patients had had reasonably acceptable diagnoses for the perinatal loss and considered further attempts at explaining the procedure or the possibility of a limited necropsy unnecessary. Alternatively, parents may fail to comprehend what has been said because of fear, anxiety, or grief.² In this respect, a leaflet in plain language explaining the advantages and disadvantages of a necropsy and what it entails may allow grieving parents to make an informed decision regarding consent.

Some of the women were dissatisfied with the findings of the necropsy or with the delay to receipt of the results. Review of the case notes for those women who were dissatisfied with the findings indicated that the necropsy did not add further to the clinical findings. The dissatisfaction is regrettable as clinical findings need to be confirmed by a properly performed necropsy, and a necropsy with no positive findings is valuable.³ Delay may be necessary so that all laboratory results can be included, but this delay may prove unsatisfactory for some parents unless it is explained when consent to necropsy is sought.

Greater emphasis should be placed on better communication,⁴ whether in obtaining consent or in relaying the findings, and in involving clinicians and pathologists at such sensitive times.⁵

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Oral submucous fibrosis

EDITOR,—H I Atrah's editorial on fibrin glue¹ helps to consolidate the theory of hypercoagulation and local coagulopathy in the oral cavity in oral submucous fibrosis. Oral submucous fibrosis is a chronic disease of unknown aetiology reported

mainly in Indians. As well as occurring in India it has been seen in Indians living in South Africa, Malaysia, Kenya, Uganda, Fiji, and Britain. For instance, in Leicester, England, which has a large number of Indian immigrants, the expected number of patients with the disease is 3000.²

After working for about 15 years on oral submucous fibrosis colleagues and I have shown that the saliva of patients with the disease contains a thrombin-like substance, identified as fibrin production factor. In contrast, fibrinolytic substances have been shown in normal saliva. Other centres in India have confirmed the presence of fibrin production factor in the disease (personal communication).³

I have shown that when citrated plasma, either from a patient with oral submucous fibrosis or from a normal person, is mixed with saliva from a patient with oral submucous fibrosis it forms a clot. The best clot formation takes place after about two to 12 hours. I believe that fibrin production factor in saliva interacts with plasma or fibrinogen in the submucous area of the oral cavity and produces dense fibrosis—there is a continuous "fibrin glue" process in the oral submucosa.

In addition to the local coagulopathy produced by fibrin glue mechanisms, defective fibrinolysis⁴ and a picture similar to that seen in well compensated disseminated intravascular coagulation seem to occur in oral submucous fibrosis.⁵ Such defective or delayed fibrinolysis could be due to a genetic predisposition or secretion of a substance like aprotinin, which delays the fibrinolytic action of plasmin. The production of such a substance in saliva in oral submucous fibrosis needs further study. Perhaps some antithrombin agent or anti-protinin substance could help stop the progression of the disease.

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Parents in the recovery room

EDITOR,—P A Hall and colleagues are in favour of parents being in the recovery room as their child recovers "whenever possible."¹ Some responses to their questionnaire, however, do not seem to support this view. On the postoperative parental questionnaire 23 of 132 parents said that they felt anxious, and the authors themselves quote Bevan *et al*, who showed that parental anxiety is associated with more behavioural disturbances in children.²

Perhaps of greater concern is the fact that roughly one in five nurses felt distracted, commenting that it seemed as though they were looking after "two patients"—that is, parent and child. During the immediate postoperative recovery period, potentially life threatening complications requiring prompt and skilled treatment by the recovery room staff may arise. The workload in the recovery room is unpredictable, with periods when all the bays are occupied being interspersed with periods when only one or even no patients are present. It is almost impossible to be sure that sufficient staff are available to care for parents at all times, and nurses should not be distracted from caring for the patients, as was the case in this study. Patients' privacy must also be respected, and it is difficult to see how this can be

achieved with present arrangements in British hospitals.

There seem to be sound benefits to the child when his or her parents are in the anaesthetic room,³ although these have not been proved. Parents may also value being in the recovery room,⁴ but the priority must be the child's welfare. Further investigation should be undertaken to evaluate any benefits to the patient against clinical risks before allowing parents into the recovery room becomes normal practice.

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Keyhole surgery

EDITOR,—In his review of a television programme on keyhole surgery Stephen Nixon makes some surprising comments regarding hernia repair.¹ I was the "hernia surgeon, giving the impression of never having seen a laparoscopic repair," who demonstrated the simplicity of the open mesh technique for hernia repair. It was performed under conscious sedation and local anaesthesia, and the patient later expressed that "it was easier than going to the dentist." This low cost procedure with minimal risk gives excellent results,² is performed as a day case procedure, and results in little postoperative discomfort, and most patients are fully active within a week. It matches the advantages, without having the disadvantages, of the more invasive keyhole method requiring general anaesthesia.

Nixon admits the risk of organ injury with the laparoscopic approach ("still less than one in 200 cases") but does not mention that such injury is virtually unknown in many thousands of open operations reported.^{3,4} He writes of a recurrence rate of 10% with "conventional repair," but with modern open procedures the recurrence rate is less than 2%.^{3,4} He mentions the "considerable mortality" of the open repair, but this occurs only in emergency situations such as strangulation and in elective operations mortality should be zero.^{2,3}

I agree that no mention was made of randomised trials, but there were time constraints. I would have liked to state that, because of the low recurrence rate associated with the open mesh repair, a randomised trial would probably require vast numbers of patients to show any significant differences. When data are already available from many sources, with reports of failure of the laparoscopic technique ("conversions"), an unacceptable rate of early recurrence, major complications, and even deaths, can it be justified to randomise and expose so many patients to the technique? Judging from the viewers' response to the programme, many people would not wish to be randomised when they realise that a groin hernia may be easily repaired under sedation and local anaesthesia.

Rather than wasting time and resources on the keyhole method, more surgeons should be trained in tensionless mesh repair under local anaesthesia. This is easily taught and has achieved results unlikely to be surpassed by the keyhole method.