

proposed by the committee are that a "single master medical record," additional to all other records, should move with the patient; and that name badges should be provided for medical and nursing staff. These are two useful suggestions, but if a really serious problem exists their adoption can do but little to correct it. We believe that the problem does not lie in the nature of doctors or of patients but in the hurried conditions of hospital work.

The committee refer to only four papers on this subject, though they state that there has been much research in America concerning it: a review of this work would have been helpful as a guide to further thinking and research in Britain. The committee might have given some attention to the special problems of children and their parents, and to the difficulties of communication with psychiatric patients and their relatives. An interesting experiment in medical education in this country apparently escaped the subcommittee's notice. Brooke² described a teaching method in which the surgeon "sits in" while the student explains to the relatives of the patient on his discharge from hospital the nature of the operation performed, the further treatment required, the care of the patient in his home, and the prognosis. If there are failures in our communication with patients, obviously Brooke is correct in thinking that the student should have some experience in what will be a difficult personal problem for him when he handles it for the first time as a junior resident.

The subcommittee suggest the consultant should be the patient's personal doctor, but they might have considered in detail the limitations practical considerations impose on this recommendation. If the consultant, the report states, does not undertake this duty in regard to any particular patient, then he may delegate it to a doctor or to the ward sister. The subcommittee might have asked themselves whether the social worker inside the hospital, the hospital almoner, could not be usefully employed in ensuring before the patient's discharge that he and his relatives have been given all the information necessary for them and for the patient's continued well-being.

Without questioning the high motives behind this inquiry and report, we very much doubt the value of tackling these problems by issuing ministerial missives. So many people these days are spending so much time telling other people what to do and how to do it that an illusion of activity is created. When there are enough hospitals, fully staffed and planned on modern lines, doctors will have time and space in which to correct the lapses of behaviour that are inevitable when faulty communications corrupt good manners. And good doctoring, as Sir George Pickering reminded us lately, is first and foremost a matter of good manners. The student

learns good manners from his teachers at the patient's bedside. He would benefit, we believe, from systematic lectures on ethics and behaviour: subjects expressly included in the Hippocratic corpus but not in the modern curriculum.

EXPERIENCES WITH PORTACAVAL ANASTOMOSIS

There is at present no effective surgical treatment for cirrhosis of the liver and for liver failure, though experimental work towards replacement of the liver is being carried out in many centres. Gastro-oesophageal bleeding certainly and ascites less certainly are the two main complications of disease of the liver and its venous system that lend themselves to surgical relief.

Any operation performed for bleeding gastro-oesophageal varices can be assessed according to its immediate mortality rate in comparison with the mortality of conservative measures. Its effectiveness in preventing further bleeding from the same source can be observed. And any complicating harmful effects it may have on other parts of the body or the body as a whole must be taken into account. But all this presupposes that the same operation is being performed on similar patients.

The patient who is presented to the surgeon with bleeding varices may appear to be otherwise perfectly healthy or in the terminal stages of liver failure. Operative mortality is then dependent on selection of cases. In a recent report L. M. Rousselot and colleagues¹ describe their experience with 104 patients for whom they performed portacaval anastomosis over a ten-year period. In the first five years the mortality from operation was 39% and in the second 9%, a reduction suggesting a general improvement in technique, selection of cases, and medical management. R. Milnes Walker and colleagues² in 50 such operations all done more than five years previously reported an operative mortality of 6%. The amount of liver failure beyond which portacaval anastomosis becomes prohibitive is now generally agreed among workers in this field, and of all the indices the level of serum albumin is probably the most helpful.

On the second count, of preventing further bleeding from the same source (and the association of cirrhosis with peptic ulcer cannot be ignored), the operation seems to have justified itself. Rousselot and colleagues claim that it should be 100% effective, but their patients include a high proportion of alcoholics who went on to liver failure too soon after operation to make the assessment of bleeding possible. A large series of patients all surviving five to ten years is necessary before a proper assessment can be made.

On the third count, freedom from harmful complications, the operation is less immune from criticism. The encephalopathy of liver disease may appear or become worse after portacaval shunt, and a case with some special features was recently reported in this journal.³ Hyper-

¹ Rousselot, L. M., Panke, W. F., Bono, R. F., and Moreno, A. H., *Amer. J. Med.*, 1963, **34**, 297.

² Walker, R. M., Shaldon, C., and Vowles, K. D. J., *Lancet*, 1961, **2**, 727.

³ Gibson, J. B., *Brit. med. J.*, 1963, **1**, 1652.

⁴ Hearn, G. W., and Paton, A., *ibid.*, 1963, **2**, 96.

⁵ Allison, P. R., *Ann. roy. Coll. Surg. Engl.*, 1959, **25**, 298.

splenism may necessitate subsequent splenectomy, and bleeding from peptic ulcer may occur (though there is no statistical evidence so far that the tendency to bleed from a peptic ulcer is necessarily increased by the operation). G. W. Hearn and A. Paton⁴ reported a few weeks ago two cases of diabetes mellitus possibly caused by portacaval anastomosis. A. H. Hunt confirms this observation in a letter (p. 320), but says he has also seen improvement in three diabetics after the shunt operation. P. R. Allison,⁵ describing a small series of patients but all followed up for more than ten years, has emphasized that the operation of devascularization of the lower oesophagus and upper half of the stomach, while greatly reducing the dangers from bleeding, is not associated with the untoward side-effects of venous anastomosis.

When all the variations in the patients, the nature of their disease, the technique of surgery, and the need for prolonged follow-up are considered it seems that there is a good case here for recommending an intensive study by a group of workers in different centres, all accepting the same standards of investigation, the same grouping of patients and their disease, and each using a standard but different surgical approach to the problem. If this could be done over a period of five years and the results analysed after fifteen years valid conclusions might emerge.

CRYOGENIC SURGERY

Focal cooling is being developed as a therapeutic measure in neurological surgery. In the treatment of gliomata G. F. Rowbotham and colleagues¹ used a cannula to pass a cooling fluid to the tumour, but its true worth has not yet been evaluated. J. S. Tytus² devised an excellent cooling probe and discussed the possible therapeutic value of rapid freezing of the brain. However, in 1961 his experience was confined to experimental work and did not include any clinical results. Recently I. S. Cooper³ has suggested that the freezing of tissues at the tip of a specially developed probe provides a worthwhile therapeutic measure for the treatment of such varying conditions as cerebral astrocytoma, "inoperable" rectal cancer, retinal detachment, and as an adjuvant to cataract surgery. Some or all of these techniques may prove to be advances. Meanwhile it is to be hoped that Cooper's report will stimulate further work in selected centres where controlled studies may be performed.

Cooper^{3, 4} reports that his work on the treatment of Parkinsonism and other disorders of movement by means of lesions created by cold in the depths of the brain has given much improved results. However, in assessing the results he made comparison with patients in whom the

lesion had been induced by the injection of "etapolin" rather than by the commonly used method of coagulation by a high-frequency current.⁵ Cooper has described a vacuum-insulated double probe in which liquid nitrogen was led down the centre tube, became converted into gas at the non-insulated tip, and then escaped via the surrounding tube. With this device temperatures as low as -50° C. could readily be obtained at the tip of a probe inserted in the brain.

It would seem from the report of V. H. Mark and colleagues⁶ that cold is potentially a better method than heat of producing reversible interruption of nervous function in the depths of the brain. These workers showed, for example, in the cat that transient pupillary dilation resulting from temporary cooling of the mid-brain could be repeatedly and consistently observed after a probe (cooled to $+5^{\circ}$ C.) had been placed within 3-4 mm. of the oculomotor nucleus. In a later publication⁷ the same group reported some effects of cooling on the function of fibre tracts and other structures in the brain. They deduced that the cooling effect was sharply localized, and indicated that further studies were in progress to provide information about the consistency of the size of the lesions created by cold. Cooper has said that the lesions are consistent in size, but has not so far published details. Information will also be required on the blandness of the lesions and the extent of their reversibility in relation to those created by heat.

RISKS OF FEMORAL PUNCTURE

Transient mottling of the leg after removal of blood from the femoral vein is not unknown to paediatricians who use "femoral puncture." It is thought that the needling of the vein causes temporary arterial spasm, but sometimes this is followed by peripheral arterial thrombosis, which may go on to complete thrombosis of the femoral artery. In one of two mishaps reported by D. C. Nabseth and J. E. Jones¹ thrombosis of the femoral artery was diagnosed and confirmed at operation, when a puncture wound was also seen in the femoral artery. The smallness of the vessels in the groin of an infant makes such damage a real risk of needling there, though even without direct damage to the artery the consequences may be serious.

These events raise doubts whether femoral puncture is justified. When peripheral veins are inaccessible and the infant is dehydrated intravenous therapy is likely to be needed, and so it would seem safer to cut down and cannulate the vein instead. If the accident does occur Nabseth and Jones suggest that early sympathetic block should be performed. Another measure which may help is intravenous administration of dextran of low molecular weight to reduce the viscosity of the blood.² If these and the general measures dictated by the child's main illness do not cause improvement, exploration of the groin may be needed. In one of the cases reported this was greatly facilitated by the use of an operating microscope.

¹ Rowbotham, G. F., Haigh, A. L., and Leslie, W. G., *Lancet*, 1959, 1, 12.

² Tytus, J. S., *Bull. Mason Clin.*, 1961, 15, 51.

³ Cooper, I. S., *New Engl. J. Med.*, 1963, 268, 743.

⁴ — and Riklan, M., *St. Barnabas Hosp. m. Bull.*, 1962, 1, 17.

⁵ Mundinger, F., Riechert, T., and Gabriel, E., *Zbl. Chir.*, 1960, 85, 1051.

⁶ Mark, V. H., Cháto, J. C., Eastwood, F. G., Aronow, S., and Ervin, F. R., *Science*, 1961, 134, 1520.

⁷ Siegfried, J., Ervin, F. R., Miyazaki, Y., and Mark, V. H., *J. Neurosurg.*, 1962, 19, 840.

¹ Nabseth, D. C., and Jones, J. E., *New Engl. J. Med.*, 1963, 268, 1003.

² Gelin, L.-E., and Thorén, O. K. A., *Acta chir. scand.*, 1961, 122, 303.