are my consultant colleagues. A general impression only was intended to be conveyed of the junior staffing situation during the time I have spent as consultant ophthalmologist in Barchester and district.—I am, etc.,

"P. GILLIVAN."

Barchester.

Haematemesis and Melaena

SIR,—In their admirable article (4 April, p. 7) Dr. K. F. R. Schiller and his colleagues report reduced mortality rates in bleeding peptic ulcer, especially in elderly patients, when a conservative operation was used instead of gastrectomy. They conclude that vagotomy plus drainage and over-sewing of the ulcer is the procedure of choice. I hope that surgical trainees will not conclude that a standard operation of this type is indicated in all cases irrespective of the general condition of the patient and the site and pathological state of the ulcer. As there is no mention in the paper of the effect which these factors might have on the choice of operation, I suggest the following general principles are relevant.

Over-sewing of a peptic ulcer cannot be guaranteed to prevent recurrent haemorrhage if the ulcer crater is large and its edges rendered pliable by inflammatory oedema or fibrosis. On the other hand with a small soft-walled ulcer suturing is safe and effective, provided cat-gut is used, so as to avoid the development of a foreign body sinus or ulcer.

Excision of a large indurated ulcer is preferable to over-sewing as healthy tissues may then be sutured together. This is applicable in the case of an anterior duodenal ulcer during pyloroplasty and to some gastric ulcers with or without a curative procedure, depending upon the general condition of the patient.

The most serious problem involves the large penetrating posterior duodenal ulcer, which of course cannot be excised with safety. In this type of case only gastrectomy with closure of the duodenal stump distal to the ulcer crater offers maximal security against further bleeding. Tamponade of the crater by tying marginal sutures over a pad of fat is effective once the ulcer has been excluded from the gastro-intestinal stream. It need hardly be added that this is a job for an experienced gastric surgeon, who should therefore always be on hand when any exploratory operation is carried out for gastro-duodenal haemorrhage.—I am, etc.,

NORMAN GIBBON.

Liverpool.

Clear Labelling

SIR,—The March edition of *B.M.A. News* draws attention to the value of writing N.P. on most prescriptions so that drug containers will be clearly labelled with the name and strength of the preparation. It also reminds us that this policy has been supported by the B.M.A. for many years and by the Committee on Safety of Drugs more recently. Perhaps the moves in this direction could be accelerated by the addition of the printed letters N.P. to the E.C.10 forms? Prescribers could still delete these letters if necessary.—I am, etc.,

JAMES S. STEWART.

West Middlesex Hospital, Isleworth.

Pregnancy and Crohn's Disease

SIR,—The survey by Dr. J. F. Fielding and Dr. W. T. Cooke (11 April, p. 76) of married women with Crohn's disease certainly suggests that pregnancy is not particularly hazardous.

However, having strong personal memories of the case reported by Blair and Allen[1] I should like to reiterate the very serious prognosis when Crohn's disease presents acutely for the first time in pregnancy. They surveyed the literature and found seven cases where this happened. In all seven, premature labour occurred and four of the babies died. At least one[2] and probably another[3] of the mothers died. It would appear that "regional ileitis beginning during pregnancy constitutes a serious threat to both the fetus and the mother."—I am, etc.,

A. H. IMRIE.

Jessop Hospital for Women, Sheffield, Yorks.

REFERENCES

1 Blair, J. S. G., and Allen, N., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1962, **69**, 648.
2 Jones, S. R. L., and Soltau, D. H. K., *Journal of Obstetrics and Gynaecology of the British Empire*, 1958, **65**, 811.
3 Crohn, B. B., Yarnis, H., and Korelitz, B. I., *Gastroenterology*, 1956, **31**, 615.

Blue Light and Jaundice

SIR,—Your leading article on blue light and jaundice (4 April, p. 5) was welcome in drawing attention to this method of treatment which, though first developed in Britain, has been almost totally neglected here ever since. However, you seem not to have been convinced firstly, that hyperbilirubinamia unassociated with haemolytic disease is potentially dangerous, and secondly, that phototherapy is both effective and harmless. There is, however, plenty of evidence from both in vitro experiments and clinical observation that hyperbilirubinaemia is potentially dangerous. Kernicterus is such a serious condition that even if its incidence is low every effort must be made to prevent it from occurring.

Recent work by G. B. Odell and colleagues[1] has shown that the major factor determining brain damage in jaundiced infants is the fraction of bilirubin which is dissociated from albumin and therefore free to diffuse into cells. In a careful study of infants who had been jaundiced during the neonatal period they found no correlation between the presence of brain damage at five years of age and the maximal serum bilirubin level, but that there was a significant correlation with the saturation of serum proteins with bilirubin in infancy. The saturation index provided a better assessment of the risk of hyperbilirubinaemia than did the serum bilirubin concentration. Their series of cases included one infant with brain damage in whom the maximum serum bilirubin concentration was only 13·6 mg./100 ml., but the saturation index was abnormal. The risks are therefore greater in infants with hypoproteinaemia. In practice it still remains difficult, however, to assess accurately when a jaundiced infant is in danger because, as your article points out, other factors like anoxia, respiratory acidosis, and the respiratory distress syndrome may be involved. But it is precisely when these conditions are present that exchange transfusion as a method of treatment becomes more difficult and dangerous. We submit, therefore, that in such circumstances the simple method of phototherapy is particularly valuable and, provided it is properly given, its effectiveness is unquestionable. It has one great advantage —that is that the infant can be effectively treated in the incubator without undue disturbance.

The dangers of phototherapy are at present hypothetical. No ill effects have been noted in any of the numerous reports which have so far been published on this method of treatment. It seems likely therefore that its dangers have been exaggerated. We would, however, agree that long-term follow up studies of treated cases are desirable and so in Chelmsford, where we have now treated over 500 cases, a follow-up study has been started.

R. E. Behrman and D. Y. Y. Hsia[2] summarized the conclusions of the Chicago symposium. Your assessment appears to have overlooked the positive recommendation they made that "phototherapy should be used for infants in whom the risks of hyperbilirubinaemia are thought to outweigh the risks of this form of treatment." We disagree therefore with the opinion expressed at the end of your leading article that neonatal units are probably not justified in adding special lighting apparatus to the already long list of important equipment needed from limited funds. While we agree that the indiscriminate use of phototherapy should be discouraged, we maintain that more should be done to stimulate research into its correct application in suitable cases.—We are, etc.,

C. B. M. WARREN.

St. John's Hospital, Chelmsford, Essex.

P. M. G. BROUGHTON.

Department of Chemical Pathology, University of Leeds, Yorks.

REFERENCES

1 Odell, G. B., Storey, G. N. B., and Rosenberg, L. A., *Journal of Pediatrics*, 1970, **76**, 12.
2 Behrman, R. E., and Hsia, D. Y. Y., *Journal of Pediatrics*, 1969, **75**, 718.

Pancreatic Extracts

SIR,—With regard to the recent Today's Drugs article on pancreatic extracts (18 April, p. 161), I should like to record a further side-effect of these preparations recently seen in three patients attending the cystic fibrosis clinic at this hospital.

Two of the children were taking Pancrex V powder, and the third Pancrex V Forte tablets. In addition they were receiving oral antibiotics because of chronic lung involvement. They presented with severe mouth ulceration and angular stomatitis causing dysphagia, loss of weight, and pyrexia. Bacteriological cultures from the ulcers were