

other than the principals, and 21% of patients did not feel the doctor came as quickly as he should.

Some form of out-of-hours cover for those unable or unwilling to provide it for themselves seems desirable. But my own experience gave little ground for complacency. Communication between doctors was poor to say the least, ignorance of relevant past details detrimentally affected management, and only half of those requiring admission were admitted. For their part, a substantial minority of patients were dissatisfied with the service they had received. We may take comfort that most illness is minor and self-limiting, but those with more serious problems seem, in our area at least, to be poorly served out of hours.

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¹ Simpson R. *Access to primary care. Royal Commission on the National Health Service. Research paper No 6.* London, HMSO, 1979.

SIR,—Dr J S K Stevenson tried hard in his article to justify the use of deputising services in general practice (27 March, p 947). He may be satisfied that such a service does not affect the care of his patients, but how is he able to act as a senior lecturer in general practice when he does not perform such a vital part of the job? His figures show that in fact the out-of-hours house calls were not too onerous, numbering only just over one a week. The benefits of a visit are not merely in quick diagnosis but in observing the factors leading to the request for a visit in psychological and social terms.

Moreover, it would seem that the "personal, primary, and continuing medical care"¹ can hardly be offered by such a practice where the patients see so many different doctors. Dr Pereira Gray² has argued very cogently for personal lists and surely university departments should be showing general practice at its best.

General practice should surely be about personal care and it disappoints me that a university department is able to ignore this in favour of the convenience of the doctors.

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¹ Royal College of General Practitioners. *J R Coll Gen Pract* 1969;18:358-60.

² Pereira Gray DJ. *J R Coll Gen Pract* 1979;29:666-78.

Laser treatment of port wine stains

SIR,—I read with great interest Dr J A Cotterill's excellent leading article on laser treatment of port wine stains (13 March, p 766). I have been using an Argon laser in the treatment of port wine stains and other vascular abnormalities for almost two years, and I agree with the majority of his comments based on the American literature. I would like to comment, however, on two points. Firstly, he states that: "The inescapable conclusion is that children under 17 should not be treated with the Argon laser." I feel that the evidence for this statement is inconclusive as in many of the American series referred to a very small number of children have been treated, and this may be related in part to the fact that much of the work in that country is carried out under local anaesthetic. I have tested many children down to the age of 4 and have obtained satisfactory test patches, and in the few

teenagers that I have treated the results appear to be satisfactory with no incidence of scarring.

Secondly, I believe that the tunable dye laser may offer certain advantages over the Argon laser in the treatment of some conditions. The power output of the dye laser, however, is extremely low at present, and, although it can selectively damage the cutaneous vascular plexus in the outer dermis, it may not cause sufficient subepidermal fibrosis, which some consider to be necessary for a good clinical result.

I agree wholeheartedly that nomenclature must be standardised and results reported in great detail so that series can be compared and new workers can enter this field using well established physical criteria for treatment.

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Removable subcuticular skin suture in acute appendicitis: a prospective comparative clinical trial

SIR,—I would like to support Mr G B Hopkinson and Mr B R Bullen's use of a subcuticular suture in acute appendicitis (20 March, p 869). Using such a suture for over 35 years, I have found it safe and cosmetically superior to conventional suturing techniques. Having tried a variety of materials, I would commend as best either fine (2/0 or 3/0) catgut or even finer nylon. Inserted in the method described in the *British Journal of Plastic Surgery*¹ it does not need removal. Other sutures, especially polyglycolic acid types, give poorer scars because even when monofilament they take a long time to absorb, and the inflammatory response which ensues from this gives thicker or keloid scars. This is much more likely if they are stranded because infection may persist in the interstices. Even when they are removed later this latter effect usually persists.

More important than choice of suture is prevention of contamination of the tissues. This can be done by using mops, soaked if necessary in Hibitane or a similar antiseptic, and the judicious use of a sucker as the peritoneum is opened. It is most difficult if the older incisions, such as McBurney's, are used, which give poor exposure for their size and hence demand more manipulation of wound edges. All is not lost, however, even if contamination occurs. If it is suspected, the suture should be started about 0.5 cm from the end of the wound (preferably at the lower end) so that a gap is left through which any serous fluid or even pus can discharge. I have used this method in somewhat over 2000 cases of acute appendicitis and in other potentially infected wounds with no mishaps to date. Certainly, also, it has never been necessary to cut sutures to drain the wound. One further caveat is that the gap in deeper, fatty layers should be closed—running or interrupted sutures in Scarpa's fascia do this magnificently.

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¹ Watts GT. *Br J Plast Surg* 1956;9:83-4.

SIR,—In their article "Removable subcuticular skin suture in acute appendicitis" Mr G B Hopkinson and Mr B R Bullen (20 March,

p 869) state: "The cosmetic appearance of wounds closed with a subcuticular suture was noticeably better than with interrupted sutures, since cross-scarring was absent."

This apparent criticism of interrupted sutures is, in fact, a criticism of the surgeon and not of the technique. If simple interrupted sutures cause cross-scarring, either they are too tight to begin with or they have been left in too long—ask any plastic surgeon concerned with cosmetic surgery.

To make a proper assessment of the cosmetic results of any suturing technique, one should examine the scar at least one year after the operation. At an earlier stage in my career I closed many wounds with subcuticular skin sutures using monofilament nylon. I abandoned the technique when it became quite clear that the late results were not nearly as good as those with carefully placed loose interrupted sutures. The reason why subcuticular sutures give a poor scar in the long run is that it is extremely difficult if not impossible to get really accurate skin apposition using a subcuticular suture, whereas with reasonable technique it should be possible to get perfect apposition with simple sutures.

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Effect of venesection on calf blood flow in polycythaemia

SIR,—I would like to comment on the interesting paper by Dr D W Milligan and others (27 February, p 619), "Effect of venesection on calf blood flow in polycythaemia." Flow in vitro is determined by Poiseuille's formula ($Q = \Delta p r^4 / 8l\eta$; where Q is the rate of flow of a liquid in a tube, p is the pressure of the liquid, r the radius of the tube, l its length, and η the coefficient of viscosity.) Hence the vessel radius represents the overwhelming influence in vitro and most likely in vivo. In disease, however, vasomotor control can be impaired. It is the rationale for haemodilution that it enhances blood flow by lowering viscosity when vasomotor autoregulation is already exhausted. In other words, even with sclerotic vessels fully dilated and unresponsive to vasomotor stimuli, a reduction of blood viscosity could still be a promising therapeutic approach.

The study of Dr Milligan and others neglects the paramount influence of vasomotor regulation on blood flow. The conclusion, venesection decreases oxygen delivery, is not necessarily true for patients with an impaired vasomotor system, such as those with intermittent claudication (and it is mostly in these cases that increase of oxygen supply to the calf is a therapeutic aim). In this study a vasomotor response might be expected since hypovolaemic haemodilution was employed.

Reducing the packed cell volume has two opposite effects on oxygen delivery: it lowers oxygen carrying capacity, and reduces blood viscosity. As the first is a linear and the second a logarithmic relation, the net influence on oxygen delivery might still be an increase. To resolve the problem a new value, the haemoglobin or haematocrit blood viscosity quotient, has been suggested, taking into account both effects.¹

Moreover, the authors state correctly that the study gives only information about total arterial inflow and not about the patho-