

aetiology, largely as a result of the many publications on the subject to which the working party's report refers. Any reduction in the incidence and severity of the intra-operative cardiovascular disturbances is principally due to the careful preoperative assessment and preparation of the patients, the use, when indicated, of alternative operations which do not require methylmethacrylate, and the meticulous care and vigilance exercised by the surgeons and anaesthetists during the procedure itself. If the importance of these simple but effective steps is overlooked again, then plainly the risks of total hip replacement will increase once more.—I am, etc.,

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1 Department of Health and Social Security. *Report of Working Party on Acrylic Cement in Orthopaedic Surgery*. London, H.M.S.O., 1974.

### Treatment of Alcoholism

SIR,—The recent review by Dr. E. B. Ritson (19 April, p. 124) of the methods of treatment for alcoholism is timely reading in view of the progressive increase of the disease. He mentioned that outpatient facilities are likely to increase and I write to comment that our experience in the community-based group at Lewes during the past three years suggests that there is much to be gained by moving therapy away from the hospital to the community.

The group considers that it has dealt at least as effectively with every patient who otherwise would have been admitted to hospital, and in some instances we have seen more progress than was ever observed during sustained inpatient care. Most inpatient units have a preselection procedure that occurs when the patient has been dried out, and this is aimed at selecting those patients who genuinely seek help and are resolved to refrain from drinking. Assuming that abstinence is desirable and that the detoxification has occurred, it is questionable whether the moment of a crisis is a suitable time for this decision to be made.

Unless one is dealing with alcoholism superimposed upon primary psychiatric disease requiring inpatient therapy there would seem to be no indication for admitting an alcoholic to a psychiatric hospital. Indeed there is evidence to show that the condition can be made worse, as this procedure very often prevents the on-going resolution of social and personal problems, and the secondary regressive effects of the institution begin to bite as each day passes. To admit a patient having forced out of him a pledge which may be inappropriate or which he is not ready to fulfil is not sound therapy.

In constructing our group we have established three basic principles, an identity with the problem, a desire to learn, and a "no rejection" clause. We have learnt that by our existence in the community we have had many more early referrals than was ever achieved under the traditional outpatient/inpatient referral system, thus making prevention of physical dependence a potential goal. Being far removed from the institution it is more acceptable to the sufferer and encourages contact at an earlier stage in the natural history of the disease. However, we have also recognized that if our therapeutic

potential is to be realized, then more facilities are necessary—such as a Samaritan-style answering service—together with facilities for providing hot soup, occupation, and a befriending service.—I am, etc.,

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### Carcinoma of the Oesophagus with "Swallow Syncope"

SIR,—We were interested to read the report of carcinoma of the oesophagus with "swallow syncope" by Drs. I. W. Tomlinson and K. M. Fox (10 May, p. 315). In 1972 a similar case came under our care at this institution.

The patient, a man of 71, presented with a 10-month history of loss of consciousness while eating his evening meal. Initially this consisted of his "head falling back" momentarily, but for two months he had been having complete "blackouts." These lasted a few seconds, were not epileptic in character, and were followed by a quick full recovery. They appeared to be induced particularly by eating heavy particles of food and were not caused by liquid. To avoid the symptom he had largely stopped eating solids and had lost a considerable amount of weight.

Barium studies at another hospital had shown a hiatus hernia with reflux and some spasm of the gastro-oesophageal junction, but oesophagoscopy demonstrated a stricture in the lower third of the oesophagus and biopsy of this revealed carcinoma. The E.C.G. showed atrial fibrillation (110/min) and T-wave changes suggesting inferolateral ischaemia. A possible connexion between the tumour of the oesophagus and his syncope was considered and an E.C.G. was recorded while he was eating his dinner. The ingestion of solids was associated with considerable belching and retching and during these events severe bradycardia with asystole lasting 5.1 s was observed. Recordings were made again while the patient was belching but after the administration of atropine 0.6 mg intravenously, and no bradycardia then occurred. Oesophageal manometry showed a normal peristaltic wave in the body of the oesophagus, but there were spastic and prolonged contractions of abnormal amplitude in the lower 12 cm.

At operation a small carcinoma was found at the junction of the middle and lower thirds of the oesophagus. This was excised and oesophago-gastrostomy performed below the aortic arch. Histological examination revealed an adenocarcinoma with involved lymph nodes. Recovery from operation was uncomplicated. The patient was seen in the outpatient clinic over a period of eight months and had no further blackouts, but he did develop a minor degree of stricture at the anastomosis and required three separate endoscopic dilatations. He died of metastases shortly after his last attendance.

This is therefore a further case in which a carcinoma of the oesophagus presented with syncope on swallowing. This symptom was relieved by resection of the tumour and did not recur despite the fact that there was still some degree of obstruction to the passage of food through the oesophagus following surgery. It seems likely that this was due to interruption of a vagal reflex mechanism by division of the two vagus nerves during removal of the oesophagus.—We are, etc.,

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### Appliances for the Disabled

SIR,—I am glad to read of your interest in the pleomorphic nature of the services concerned with appliances for the disabled (14 June, p. 579). As with many problems in the health and social services, reports are prepared from several sources but with no one accepting responsibility for ensuring continuous review or implementing their recommendations. The present situation for aids is not unlike that of a decade ago in another expanding branch of therapeutics—drugs, though without the prompting emotive force of prominent adverse effects.

I venture to suggest that what is required is a "Dunlop" who will produce an organization with terms of reference akin to those of the Medicines Commission. Obviously the emphasis should be on evaluation of effectiveness to solve clinical problems, noting that these include aspects of the patient and of his environment as well as of the appliance. Standard skills for clinical trials are required, but with the engineer replacing the pharmacologist. Closer relations need to be established, from those involved with initial development of a new appliance through to those responsible for its maintenance in routine service. Only the Departments of Health have the means to solve this real need, and I hope they can be prompted to have the will to do so.—I am, etc.,

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### Breast Feeding and Maternal Nutrition

SIR,—The D.H.S.S. report on "Present-day Practice in Infant Feeding"<sup>1</sup> expressed the unanimous opinion of the working party that the best food for babies is human breast milk and recommended that steps be taken to encourage all mothers to breast-feed their babies, preferably for the first four to six months.

The problem of achieving this desired aim was recognized as complex, yet as Dr. P. L. Sousa (1 March, p. 512) reminds us, it is not confined to the sophisticated communities. He recommends the use of metoclopramide as a potent stimulator of prolactin release and this would seem reasonable if there was a hormonal problem. Gunther<sup>2</sup> claims that if breast-feeding fails it is mainly for nutritional or psychological reasons. We would be concerned if metoclopramide were to be used where the cause of lactation failure was nutritional. We have already reported evidence that, under extreme conditions, nutrition appears to affect the milk lipid both quantitatively and qualitatively.<sup>3,4</sup> Such effects can be observed in both African and European mothers and will be reported in detail elsewhere, but in the meantime we wish to suggest that a pharmacological forcing of the mammary gland would not be in the best interests of the mother or child. Before resorting to pharmacology to correct a premature failure of lactation it would seem wise to examine the nutritional status of the mother and her milk.

For example, lipid is the principal energy component of the milk and its quantitative determination is simple.<sup>5</sup> Though single determinations can be misleading because of