

SIR,—The picture of casualty departments put forward by Mr. Keith Norcross in his *Personal View* (18 November, p. 421), cannot be allowed to go unchallenged. We are given a horrible picture of the casualty department in his own hospital. I can assure readers and Mr. Norcross that not all casualty departments are as horrible as that. The large numbers of applicants for the few senior house officers posts both in my time and now with my successor in Leeds are not all masochists, nor are forced into the work by the demands of the royal colleges. At a more senior level a registrar trained in another hospital worked for six months in Casualty as part of the registrar rotation. He wrote and told me after he left, that he had not had a more instructive or enjoyable time since he qualified.

Mr. Norcross states that most of the work is that of a G.P. Such a statement suggests that Mr. Norcross has had little experience of Casualty and probably none at all of general practice. It is certainly contrary to the experience of my last twenty years and to the opinions of my G.P. clinical assistants. After retirement I moved to this small coastal resort. As holiday relief I have worked in the casualty department of the local hospital and also acted as assistant for my G.P. friends: I found little similarity in the types of patients.

The patients in Casualty are made up of those at one extreme with the trivial lesions bemoaned by Mr. Norcross. Often these lesions are so trivial that they scarce need medical attention at all. I often thought that these patients used the hospital visit as an excuse for being late for or being off school or work. With the appointment system growing in general practice they will increasingly use the hospital. Even then they do not amount to more than 10%; this does mean that in a big hospital there may be 15-20 a day, and when several come together the burden becomes noticeable. At the other extreme, there are the seriously ill or injured, also amounting to no more than 10%, who need all the skills of modern medicine to preserve life or limb. But the vast bulk of the work lies in between with patients who are not in serious danger of losing life or limb, but have some lesion which they think is in need of urgent attention. Skilled treatment of this lesion can reduce the pain, distress, and disability to a small fraction of what it would be without this skill. This after all is what most of medicine is about, for very few doctors spend their days rushing about saving life or limb.

The skills needed for the casualty patients have to be learned over a long period before they can be acquired and then taught to junior staff who are only present for a short while. This is a consultant's work and not that of a G.P. or an absentee orthopaedic landlord. Then there will be a happy department staffed by a proud and happy staff doing expeditious and expert work. Many hospitals are doing this already and with the present increase of consultants of this calibre, there will be more in the future.—I am, etc.,

M. ELLIS

Heysham, Lancs.

Malaria in Immigrant Pakistanis

SIR,—According to your epidemiological report (9 September, p. 652) 91 cases of

malaria due to *Plasmodium vivax* were reported by laboratories in the United Kingdom during 1971 and only 14 of these were classified as occurring in immigrants from malarious areas. We have experienced difficulty in persuading many immigrant Pakistani patients to attend hospital, and have found that when this can be overcome the incidence of *P. vivax* malaria in this population appears to be considerably higher than might be expected from published figures.

Until recently not more than three cases of *P. vivax* malaria have been seen annually in this hospital, although there is a considerable local immigrant population, many of whom come from areas where this type of malaria is endemic. Starting five months ago an attempt has been made to persuade Pakistani patients with symptoms suggestive of malaria to attend the laboratory to have a blood film examined, although in most cases they were neither persuaded to come into hospital nor to have further investigations performed. The result has been that 12 cases of malaria due to *P. vivax* have been diagnosed within this period of five months. All these patients have either come from Pakistan as new immigrants or recently returned from holiday there, and most of them come from one local practice. Treatment has been carried out at home, although it has not always been possible to assess the effectiveness of this with follow-up blood films.

The mortality from *P. vivax* malaria is, of course, extremely low, but recurrent fever in Pakistani patients seems not infrequently to remain undiagnosed.—We are, etc.,

J. A. EASTON

Wexham Park Hospital,
Slough

M. A. MARGHOUB

Slough

Early Radiology in Acute Gastrointestinal Haemorrhage

SIR,—A casual reader of the interesting paper by Dr. R. N. Allan and others (4 November, p. 281) might conclude that early barium-meal examination is an accurate method of diagnosing the source of acute bleeding. The authors exclude all patients with acute erosions and confine their assessment to those patients with a fairly definite diagnostic endpoint (i.e., operation or necropsy). However, since patients shown to have a lesion radiologically are more likely to be referred for surgery than those with negative findings, this method of selection automatically biases the study in favour of radiology. Our first study of endoscopy in acute bleeding¹ was biased in favour of endoscopy since some patients were referred for examination because of negative or equivocal x-rays. Thus of 50 patients with a firm diagnosis who had undergone both endoscopy and radiology, 31 were "barium negative." Results of a more substantial endoscopic survey will be published shortly.

There are two major drawbacks to early radiology in acute bleeding. X-rays cannot detect surface lesions, and when a lesion is shown it may not be the bleeding source. At endoscopy we are finding more than one potential bleeding source in about 10% of patients—usually oesophagitis or gastric erosions in the presence of duodenal ulceration. Others have reported figures as high

as 33%.² Patients with known oesophageal varices are as likely to be bleeding from haemorrhagic gastritis.³ In Palmer's series⁴ of 860 patients, 60% of those with a previously diagnosed lesion were bleeding from another site. It would seem a pity to perform a hazardous emergency operation for radiologically proved ulcer or varices when bleeding is in fact due to erosions or oesophagitis (an underrated source).

For definitive diagnosis there can be no substitute for visualization of the bleeding point. Modern fiberoptic endoscopes allow a full survey of the oesophagus, stomach, and duodenal bulb;⁵ with diazepam sedation; examinations are remarkably well tolerated by ill patients of all ages, without interference with transfusion or monitoring apparatus. We have been able to make an unequivocal diagnosis in over 80% of cases of gastrointestinal haemorrhage by means of early oesophago-gastro-duodenoscopy. Blood in the stomach may prevent a complete survey, but rarely obscures the lesion, and routine gastric lavage is unnecessary. There is no evidence that endoscopy precipitates further bleeding.

Modern fibrescopes are rapidly becoming available in all district hospitals. The problem of emergency endoscopy is simple—who has the time and energy to do it? When a good endoscopy service is available, barium radiology is rarely indicated in the acutely bleeding patient.—I am, etc.,

P. B. COTTON

St. Thomas's Hospital,
London S.E.1

- 1 Cotton, P. B., and Rosenberg, M. T., *British Journal of Hospital Medicine*, 1971, 6, Equipment Supplement, p. 52.
- 2 Paul, F., Seifert, E., and Otto, P., in *Proceedings of International Symposium, Prague/Carsbad, 1971*, p. 64. Basel Karger, 1972.
- 3 McCray, R. S., Martin, F., Anur-Ahmadi, H., Sheahan, D. G., and Zamcheck, N., *American Journal of Digestive Diseases*, 1969, 14, 755.
- 4 Palmer, E. D., *Diagnosis of Upper Gastrointestinal Haemorrhage*. Springfield, Illinois, Thomas, 1961.
- 5 Cotton, P. B., and Williams, C. B., *British Journal of Hospital Medicine*, 8, Equipment Supplement, 1972, p. 35.

Alcoholic Cirrhosis of the Liver

SIR,—I have suspected for some time that the incidence of chronic alcoholism as a cause of cirrhosis of the liver is much higher in the Liverpool region than that reported from other parts of the country—for instance, by Sherlock¹ and by Stone *et al.*² The former found, in a series of 561 cases of cirrhosis, that only 134 (24%) were alcoholics, and the latter found 52 (33.5%) alcoholics in a group of 155 cases. In both these series the incidence of alcoholism was more than twice as high in the men (34% and 46% respectively) than in the women (14% and 16%).

My cases of cirrhosis have been unselected and referred from only the local area and therefore it has taken a long time to collect a sufficiently large number from which to draw significant conclusions. My definition of alcoholism is similar to that of other workers—namely, the daily consumption of more than five pints of beer, half a bottle of spirits, or one bottle of sherry; many such patients consume a mixture of beer, spirits, and wine. I have now seen a total of 67 cases (36 males, 31 females) over the past 11 years. Forty-two of these (63%) admitted that they had been consuming excessive quantities of alcohol for a long time.