

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

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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.,

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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.,

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- 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.

The admitted incidence of alcoholism in the males was 27 cases (75%) and in the females 15 cases (48%). The actual incidence of alcoholism is almost certainly higher than this as many alcoholic patients, particularly women, are very anxious to conceal the truth.

In Boston, Massachusetts, the proportion of alcoholic cirrhosis was given by Garceau and Chlamers³ as 83% (87% of males and 68% of females) and it has been considered that the aetiological factors of cirrhosis in the U.S.A. differ from those in Britain. But my experience in Liverpool is closer to that reported from Boston than from London and Birmingham. It would be interesting to hear the observations of physicians in other regions of this country.—I am, etc.,

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¹ Sherlock, S., *Diseases of the Liver and Biliary System*, 4th edn., p. 403. Oxford and Edinburgh, Blackwell, 1968.

² Stone, W. D., Islam, N. K. R., and Paton, A., *Quarterly Journal of Medicine*, 1968, 37, 119.

³ Garceau, A. J., and Chalmers, T. C., *New England Journal of Medicine*, 1963, 268, 469.

Medical and Social Problems

SIR,—In "Second Opinion, Please" (28 October, p. 224) an experienced general practitioner requests the admission of a patient to hospital. The consultant geriatrician ("Bobby"), who apparently knows the general practitioner ("Graham") very well, declines to do so without a report from the hospital social worker.

This appears to represent an astounding lack of trust in the judgement of a colleague, which I certainly hope does not spread to other fields of medicine. Surely a "second opinion" could have been more reasonably provided by the offer of a domiciliary consultation. The social worker's visit was entirely unproductive in judging the necessity for admission.—I am, etc.,

R. E. W. OLIVER

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** Dr. Oliver sent a copy of his letter to the authors of the "Second Opinion, Please" he comments on, so it is possible to print their reply below.—Ed., B.M.J.

SIR,—Dr. Oliver has a valuable point, but he misses the one that we were trying to make.

Where a request for admission to the geriatric unit is made on medical grounds—that is, for the investigation and treatment of the patient herself—then immediate admission is offered as with all other hospital departments. Where, however, admission is requested primarily on social grounds—that is, for the relief of other people rather than for the treatment of the patient herself—then there is always a social problem which requires expert assessment. Long experience has convinced us that in this situation a social worker can help more than a doctor. Moreover, on the south coast, or Costa Geriatrica, there are many private old people's homes and nursing homes. These can often be used to save a hospital bed and the social worker is often the best judge of this.

We would agree with Dr. Oliver that when an admission to the geriatric unit is

requested on medical grounds preliminary screening by a social worker is not necessary.—We are, etc.,

G. M. HUNTER
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SIR,—I should like to add a comment to the admirable report on the medical and social problems of two elderly women (28 October, p. 224). Dr. Graham M. Hunter's patient, aged 78 and subsequently found to be suffering from pernicious anaemia, ascribed her symptoms to "old age." These were abolished by correct diagnosis and treatment of a pathological condition. Her sister's case illustrates the same point: an incontinent, senile woman, she responded favourably to treatment for hypothyroidism and her decline into "old age" was checked.

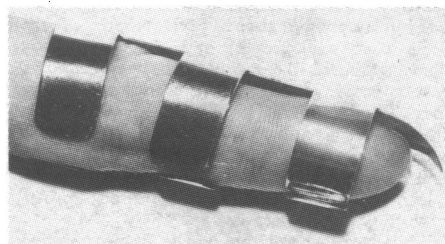
These women were fortunate in having an interest taken in their medical and social problems. There must be many elderly people, however, who accept all manner of physical and mental infirmities as signs of old age and who do not trouble their doctors until some catastrophe overtakes them. But in this day and age it is as bizarre to ascribe to old age itself ills and disabilities accompanying it as it is to ascribe schizophrenia to being possessed by the devil. The elderly need to be enlightened about the potential which they possess for general improvement in health, for recovery from illnesses and operations, for rehabilitation—the potential upon which the whole fabric of geriatric medicine is built. Thus enlightened, they may become less likely to neglect their health; I doubt whether many will become hypochondriacs. Perhaps the gloomy prognostications about the ever-increasing numbers of geriatric beds will then prove wide of the mark. Pathological ageing is manifest everywhere, and much of it is preventable and curable; physiological ageing is very difficult to track down. Ill health and old age are separate entities, but in the lay mind they are confounded through ignorance and tradition. I would suggest that it is time to diminish the ignorance and to review the tradition.—I am, etc.,

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Amniotic-membrane Rupturer

SIR,—"Blind" artificial rupture of the amniotic membranes using the traditional Koche's forceps can occasionally be a rather difficult and traumatic procedure. With this in mind, a small digital instrument (see Fig.)



has been devised that has proved very useful in this procedure.

The instrument is slipped on to the middle finger, which is then passed through the

cervical os. The membranes can then be felt against the tip of the finger and by a single movement the point of the instrument can be made to rupture the membranes. The instrument has been produced and is available from Down Brothers, Mayer and Phelps Ltd.—I am, etc.,

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Unusual Bullet Embolus

SIR,—Bullet embolization is rare. Habein and Christensen¹ recorded 30 cases from the literature, and Fattah and others² reported a bullet embolus of the profunda femoris artery in a man who survived for 10 days after sustaining a penetrating gunshot wound of the heart. Embolization of the bullet occurs when the missile gains access to the blood stream by penetrating the heart wall or the aorta. Of the 29 cases of penetrating injuries of the aorta or the heart analysed by Garzon and Gliedman³ nine survived the original cardiovascular injuries. A common site of lodgement of the bullet is the femoral artery, but it may be carried to the popliteal or even posterior tibial artery. One of us (A.F.) has seen two cases with bullets lodged at the bifurcation of the abdominal aorta. Occasionally, bullets embolize in the arteries of the upper extremities.³ In the following case the bullet lodged in an unusual site.

A 57-year-old man was found dead in a street beside his cab. He had a gunshot wound on the upper lateral aspect of the right shoulder. At necropsy the bullet was found to have passed to the left, slightly downwards and backwards. It had perforated the upper lobe of the right lung and entered the heart through the anterolateral wall of the right ventricle. From the ventricular cavity the bullet was propelled into the pulmonary trunk and carried as an embolus into the pulmonary artery to the lower lobe of the left lung, from where it was retrieved. The bullet measured 5 mm in diameter and 11 mm in length. The cause of death was haemopericardium and haemothorax.

It is important to localize the bullet with the help of radiographs so that it can be removed. If in a case of gunshot wound with no exit hole the bullet is not seen in the radiographs in the general direction of fire additional films of the extremities should be obtained. In non-fatal cases bullet emboli to the extremities may cause severe ischaemic changes leading to gangrene. Repair of the primary penetrating injury of the heart or the aorta should be carefully considered to prevent possible delayed haemorrhage. In fatal cases retrieval of the bullet may help in the identification of the gun used.—We are, etc.,

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¹ Habein, H. C., and Christensen, R. K., *Rocky Mountain Medical Journal*, 1966, 63, No. 5, 36.

² Fattah, A., Shah, Z. A., and Mann, G. T., *Journal of Forensic Medicine*, 1968, 15, 139.

³ Garzon, A., and Gliedman, M. L., *Annals of Surgery*, 1964, 160, 901.

Infections in Hospital

SIR,—In your leading article on this important subject (21 October, p. 127) you rightly comment that it is not possible to