than 10 mg. No local analgesic preparation is used. This technique, of course, is not new; moreover, many different combinations of local and general anaesthesia and analgesia are used for this type of endoscopic examination.

The chance of aspiration of pharyngeal contents, either salivary or from the stomach, is always present, irrespective of the technique used, and it is salutary to note that even the use of a cuffed endotracheal tube does not afford complete protection. Dr. S. Mehta[1] has recently described aspiration in 18 out of 90 patients following removal of a cuffed endotracheal tube. He advocated careful placement of the endotracheal cuff just beyond the true vocal cords or the use of a 10° head-down tilt with suction through the endotracheal tube at the end of the operation.

Drs. Prout and Metreweli point out that the aspiration of pharyngeal contents during endoscopic examination of the upper gastrointestinal tract is rarely followed by serious complications. However, if one wished to minimize this aspiration with a technique not using a cuffed endotracheal tube, then probably nasopharyngeal suction during the procedure would be advisable.—I am, etc.,

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1 Mehta, S., *British Journal of Anaesthesia.* 1972, **44**, 601.

Delay in Labour

SIR,—With reference to Mr. D. D. Mathews's suggestions in his letter (25 November, p. 487) regarding times to send for medical aid in labour, I wonder whether the second-stage durations are not rather too long.

Apart from maternal or fetal distress the main indication for intervention in the second stage is failure of progression of the presenting part, and I feel it is this fact that should be stressed to pupil midwives and medical students. If the multiparous patient does not deliver within 30 minutes or the primigravid one within 60 minutes, there is usually a cause requiring mechanical assistance. Also, it is unlikely that less than 20 minutes will elapse between a midwife seeking medical help and the subsequent delivery of the baby. Thus in providing a guide, I consider it would be wiser to quote the shorter times.—I am, etc.,

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Carcinoembryonic Antigen in Urine of Cancer Patients

SIR,—Mr. R. R. Hall and others reported recently (9 September, p. 690) on the demonstration of increased levels of carcinoembryonic antigen (C.E.A.) in the urine of patients with urothelial carcinoma by the radioimmunoassay method. Also, they stated that "C.E.A. does not appear in the urine with most non-urothelial tumours even when the plasma level is raised unless such tumours involve the urothelium secondarily . . ."

We have reported[1 2] the finding of C.E.A. in the urine of patients with colonic carcinoma by means of the immunodiffusion test. Urine specimens collected over 24 hours were dialysed overnight against distilled water in 23 × 32-in (58·5 × 81·3-cm) Visking tubes and lyophilized or concentrated by ultrafiltration through a Diaflo type UM-10 ultrafilter. Perchloric acid extracts were obtained from parts of each urine specimen. Specific antisera were prepared according to the method described previously[2] and the specimens were also tested against antiserum obtained from Dr. P. Gold's laboratory in Montreal.

Of 18 urine specimens from patients with colo-rectal cancer, two were found to be C.E.A.-positive against our antisera and against antiserum obtained from Dr. Gold. Neither of these two patients was known to have urogenital involvement by his neoplasm. None of 107 urine specimens from other cancer patients and 50 from non-cancer patients and healthy subjects were found to contain C.E.A. by the immunodiffusion test. We feel that the use of a more sensitive technique such as radioimmunoassay will increase the incidence of C.E.A. detected in the urine of cancer patients, especially those with increased C.E.A. levels in plasma.

Further, Mr. Hall and his co-workers suggested that measurement of urinary C.E.A. is of clinical diagnostic value in the detection and follow-up of urothelial carcinomas. Our two patients with positive C.E.A. in the urine were treated with 5-fluorouracil intravenously and both experienced subjective and objective tumour response. On repeating the test for C.E.A. in their urine during tumour regression, none was found by the method used. We suggest that serial follow-up of the plasma and/or urinary level of C.E.A. may aid in the evaluation of tumour responses to therapy.—We are, etc.,

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1 Kithier, K., Al-Sarraf, M., Cejka, J., and Vaitkevicius, V. K., *Proceedings American Association for Cancer Research*, 1972, **13**, 66.
2 Kithier, K., Al-Sarraf, M., and Cejka, J. *Proceedings Second Conference and Workshop on Embryonic and Fetal Antigens in Cancer*, In press.

Methylcellulose in Diverticular Disease

SIR,—In his paper on the effects of methylcellulose on intracolonic pressures in diverticulosis (23 September, p. 729) Mr. John Hodgson showed that in the cases he studied a manufactured bulk-former lowered these pressures and was helpful clinically. While his experience supports the view that a high-residue diet will lesson the pressures of the colon and relieve symptoms, it is a pity that he studied cellulose in preference to unprocessed bran.

Admittedly it is safe, by and large, to maintain patients on methylcellulose, but it must not be forgotten that only last year attention was drawn[1] to the fact that "hydrophylic colloid purgatives have very occasionally caused bolus obstruction," cases reported in 1965 by Souter[2] being cited. There have been other reports of faecal obstruction after the administration of either bran or granules made from natural unprocessed gum.—e.g., sterculia. This is probably due to their tendency to remain particulate when wet, whereas other bulk-formers may clump and cause obstruction.[3]

It would be a pity if Mr. Hodgson's study, albeit unintentionally, persuaded clinicians that methylcellulose was the "drug of choice" in the treatment of diverticular disease. Unprocessed bran is the most natural, safest, and cheapest material available and, now that finely ground bran is on the market, most patients can take it without difficulty. However, a few will not tolerate bran and these should be given the safest alternative, which is sterculia.

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1 *Lancet*, 1971, **2**, 253.
2 Souter, W. A., *British Medical Journal*, 1965, **1**, 166.
3 Painter, N. S., *Lancet*, 1971, **2**, 381.

Use of Surgical Beds

SIR,—We are all aware that there are marked discrepancies in the waiting times for surgical beds in various parts of the country and that in some areas patients may have to be signed off as unfit for weeks, months, or even years before simple matters such as hernias, gall bladders, or haemorrhoids can be attended to. At the same time, owing to the shift of population from Central London, there are, to my knowledge, hospitals in London which, though busy, can arrange an outpatient's surgical appointment within a week of request and the patient, if his condition is of any urgency, can be admitted within the next two or three weeks.

Some enterprising general practitioners have taken advantage of this situation, and it would seem that if some central national information bureau could be established where comparative waiting times could be listed this might be a help to both practitioner and patient alike.—I am, etc.,

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Radioactive Bromide Partition Test in Tuberculous Meningitis

SIR,—Our two patients who were included in the series reported by Dr. B. K. Mandal and his colleagues (18 November, p. 413) offer a striking illustration of the diagnostic value of the radioactive bromide partition test. The patients were immigrants and were man and wife. A diagnosis of tuberculous meningitis was established in the husband and when the wife was admitted some three months later, also with a lymphatic meningeal reaction, the same diagnosis was naturally suspected. The partition test, however, showed the meningitis to be of viral origin, and the measles antibody titre later rose from 1/640 to 1/2,560. The partition test thus served to refute what had at first appeared to be a promising clinical lead.—We are, etc.,

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Insulin Abuse by a Drug Addict

SIR,—With the increasing frequency of drug addiction, doctors are often faced with serious clinical problems, occasionally diagnostic, particularly when the history of addic-

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