

disadvantage. Not only does he have to communicate with the patient and often take a clinical history, but unless he can provide an accurate, easily understood report at the end of an examination his time has been wasted.—I am, etc.,

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Surgery on Day Patients

SIR,—Mr. R. T. Burkitt (10 November, p. 360) tells us that he has "been practising 'day case surgery' on selected patients for many years. There have never been any problems, and the only people involved have been the surgeon, the patient, and his general practitioner."

May we conclude that he operates solely under local anaesthesia? If not, then he shows the same disregard for his anaesthetist which is such a lamentable aspect of some surgical thought and practice. His patients may well be "selected," but suitability for day case surgery should be based on anaesthetic as well as surgical considerations.

This is only one of several valid points made in the document H.M. (73)22, and if Mr. Burkitt has not already agreed on appropriate criteria with his anaesthetic colleagues, then the appearance of this memorandum is not merely timely, but long overdue.—I am, etc.,

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Hazard of Petrol Shortage

SIR,—I was interested to read the article by Drs. R. L. Barnes and D. S. Wilkinson on epidermal necrolysis due to paraffin (24 November, p. 466). I would like to report a similar case due to petrol which is relevant to the present fuel crisis.

Last week a patient aged 36 attempted to siphon petrol from a friend's car as she thought she would be unable to obtain a can of petrol from a garage for her car. She sucked intermittently for one hour through a rubber hose pipe inserted into the tank, after which she felt nauseated and drunk. She had not succeeded in drawing up any petrol but had inhaled the vapour. Shortly afterwards she vomited and had one episode of diarrhoea. She also noticed extensive perioral blackening of the skin which peeled off on washing.

When seen in the surgery the following morning she had a well-demarcated perioral erythema in which vesicles appeared later. She thus had had a chemical burn from the petrol vapour. This has settled with bland local treatment. No doubt further cases may be seen in the near future.—I am, etc.,

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Effect of Bran on Bowel Function

SIR,—We were most interested to see the paper in which Dr. M. A. Eastwood and his colleagues (17 November, p. 392) report the effects of increased dietary fibre (bran) on

intestinal transit rate. Their results are very similar to those found in our previous study,¹ showing that fibre speeds up transit in subjects whose transit time is initially three days or more, whereas transit rate is unaltered or actually decreased in subjects whose rate is initially fast (transit time < 2 days). The authors of the paper have not done their data justice, however, in saying that "intestinal transit time did not significantly alter." What they mean is that the methods they chose for the statistical analysis (details of which are not given) were unable to demonstrate the statistical significance of their results. If they had analysed the transit-time data shown in their figure in the three ways described in our paper their conclusions would have been different.

Thus in their four subjects whose transit time was initially slow (> 3 days, mean 94.0 hours) bran produced a significant shortening of transit time (mean value after bran 50.0 hours, $t=3.47$ (paired t test), $P < 0.025$). Conversely, in those subjects whose initial transit time was relatively short (< 2 days, mean 28.75 hours) bran produced an increase in transit time (mean value after bran 37.0 hours, $t=1.78$, $0.05 < P < 0.10$). A 2-day (44-54 hour) transit time was seen in none of the subjects initially, but was found in six of the eight subjects after bran ($\chi^2=6.0$, $P < 0.025$). Of these six, four had started with a slower and two with a faster transit.

The findings of Dr. Eastwood and his colleagues are thus both significant and of great interest in confirming not only what might be expected—that bran speeds up slow transit—but also in supporting the suggestion that in some circumstances bran may actually slow down a fast transit. The implications of this were discussed more fully in our previous paper.¹—We are, etc.,

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¹ Harvey, R. F., Pomare, E. W., and Heaton, K. W., *Lancet*, 1973, 1, 1278.

SIR,—Dr. M. A. Eastwood and his colleagues (17 November, p. 392) do not state what form of bran was used in their studies. In the past this has, so far as I am aware, always been processed bran, but in 1931 I started experimenting with unprocessed bran and described the results of the use of this material in 1941,¹ in 1962,² in 1966,³ and yet again in 1972.⁴ As the result of my experience, not only in thousands of personnel in H.M. ships at sea, but also when carrying out specialist duties for some 20 years in naval hospitals, I am convinced that unprocessed bran approximately halves the average intestinal transit times occurring with a Westernized diet. This figure was supported by planned provisional studies by Dr. G. D. Campbell and myself^{5,6} on Africans living on unrefined maize and later confirmed in much more comprehensive studies by Burkitt et al.⁷

As regards the slowing down, in some cases, of rapid transit time, I am convinced, again from my own experience, that this is not due to any direct effect of bran on the

intestines, which I have always found to be solely aperient, but to its indirect effect of cutting down to some extent the over-consumption that invariably accompanies a refined Westernized diet and which results in abnormal bacterial activity in the gut and the production of the evil-smelling skatole, indole, and other irritant toxins.⁸ I am naturally very pleased to note the rapid spread of unprocessed bran in this country, including certain hospitals in Reading, Bristol, London, and elsewhere, but I think it would be a pity if this spread, based on its natural aperient powers, led to much of its employment in non-specific diarrhoea without constipation, where I am convinced that the dominant treatment lies in the cutting down of consumption of refined sugar in all its forms, which is a far worse cause of over-consumption and evil-smelling motions than is any lack of bran.⁸—I am, etc.,

T. L. CLEAVE

Fareham, Hants.

- 1 Cleave, T. L., *British Medical Journal*, 1941, 1, 461.
- 2 Cleave, T. L., *British Medical Journal*, 1962, 1, 191.
- 3 Cleave, T. L., and Campbell, G. D., *Diabetes, Coronary Thrombosis and the Saccharine Disease*. Bristol, John Wright, 1966.
- 4 Cleave, T. L., *British Medical Journal*, 1972, 2, 408.
- 5 Cleave, T. L., and Campbell, G. D., *British Medical Journal*, 1968, 1, 579.
- 6 Campbell, G. D., and Cleave, T. L., *British Medical Journal*, 1968, 3, 741.
- 7 Burkitt, D. P., Walker, A. R. P., and Painter, N. S., *Lancet*, 1972, 2, 1408.
- 8 Cleave, T. L., *Lancet*, 1973, 1, 1443.

Royal Fleet Auxiliary

SIR,—Many doctors are unaware of the existence of the Royal Fleet Auxiliary and its close association with the Royal Navy. There are some 22 R.F.A. ships carrying doctors, and medical services are well up to date. It may be of interest to doctors approaching retirement from the N.H.S. to know that the above service offers opportunity for sea travel to most parts of the world, with advantages for study, comfortable accommodation, and an abiding interest in medicine.—I am, etc.,

F. R. CORFE

R.F.A. *Olwen*,
B.F.P.O. Ships

W.M.A. and Racial Discrimination

SIR,—Your leading article (3 November, p. 245) and report of the 27th World Medical Assembly in Munich (*Supplement*, 3 November, p. 23) will probably have misled many of your readers into falsely concluding that the future bodes well for the revitalized World Medical Association. Having attended the whole Assembly, I am sad to report a different story. I believe that in the last two days in Munich the delegates to the Assembly (including those of Great Britain) by their parochialism and political insensitivity successfully destroyed the hopes of transforming this small, European-dominated club into a truly international medical body.

This tragedy occurred as a result of the Assembly's refusal to deal with the specific issues involved in Ghana's resolution on "colour discrimination in medical practice." This resolution merely asked the Assembly to condemn colour discrimination in medical

practice "for the peoples of the world" and instructed the W.M.A. Council fully to investigate this matter in South Africa and "any other parts of the world considered necessary." Despite the alarmist letter from Dr. G. W. Gale (29 September, p. 692) no attempt was made to expel South Africa from the W.M.A. as had been done by the Commonwealth Medical Association in 1970. Ghana stressed that her resolution was not intended to indict but to help the Medical Association of South Africa in its difficult task. Ghana pointed out that there were few African members in the W.M.A. and that the W.M.A.'s attitude to colour discrimination would probably affect potential Black membership. One might have hoped that these warning notes would have reminded the Assembly that it was handling an issue whose implications stretched far beyond South Africa's boundaries.

I would like to draw your readers' attention to certain important facts, mostly omitted from the *B.M.J.* report.

(1) The chairman of the Resolutions Committee (Dr. J. K. Bremer, South Africa) resigned to avoid having to preside over the discussion of Ghana's resolution.

(2) South Africa, backed by Britain, West Germany, and others, tried to block the acceptance of the newly constituted Resolution Committee's report. The long procedural wrangle was ended only by a presidential decision that Ghana's resolution should be accepted for debate.

(3) The Munich Assembly showed inconsistency in both the type of ethical problem it was prepared to handle and its policy on naming the country involved. It dealt with issues such as the amputation of hands for theft and torture, but not with a well-known and specific case of colour discrimination. It did not hesitate to name Libya in the former case, but refused to mention South Africa in the latter. In their embarrassed side-stepping, those who felt that "rightly in the final resolution the reference was made world wide" might be accused of indulging in "polite window-dressing" (Ghana's words to the Assembly). Ghana's resolution clearly included the worldwide situation.

(4) Before the final vote on Australia's and West Germany's amendments the chairman of the Council assured the Assembly that a full investigation into colour discrimination in South African medicine would go ahead even if the amendments were carried.

Those delegates within the W.M.A. who were intent first on blocking this vital resolution and then on watering it down—and this includes the B.M.A. delegates—should fully realize the implications of their actions. It is significant that Ghana officially recorded that her association would have nothing to do with the amendments proposed. It is very relevant to the W.M.A.'s future that when the Assembly succeeded in carrying these amendments all the Black countries, as well as Turkey, Uruguay, and Venezuela, voted against Ghana's amended resolution. The interesting contrast with the votes of South Africa and the entire European block did not pass unnoticed.

As I left Munich those opening remarks of Dr. D. P. Stevenson—"We must open the doors wider" and "The 1977 Assembly will be held in Africa"—took on another

meaning. In calling for an enlarged membership, had the W.M.A. Assembly forgotten that there is such a body as the Organization of African Unity? Had it also forgotten the close ties between the so-called "third world" and eastern-block countries? It had clearly forgotten (or maybe never realized?) the far-reaching implications of the colour/ethnic group issue in this vast tract of world medicine which is, alas, now likely to remain unrepresented in the so-called "World" Medical Association.

Perhaps there is still one last chance for the W.M.A. Though many of us are disillusioned in the W.M.A.'s performance, no one should doubt the skill and vast international experience of its new Secretary-General, Sir William Refshauge. Those of us who still passionately believe in the need for a truly representative international medical body now look to him to do everything possible to heal the wounds inflicted by the Munich Assembly.—I am, etc.,

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SIR,—More remarkable than the proposed "naming" of South Africa by a group of member associations of the World Medical Association which that body at Munich, in its wisdom, did not agree to, was the fact that the nine member associations who, by voting *against* the amended motion, *ipso facto* actually voted *for* "discrimination on grounds of religion, race, colour, or politics of any form in the training of medical practitioners and in the practice of medicine and in the provision of health services to the peoples of the world."

Perhaps it was your editorial caution which deterred you from publishing the names of the nine member associations (3 November, p. 245, and *Supplement*, p. 26). For us to know who they are is of considerable significance in view of the very nature of the resolution.—I am, etc.,

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Treatment of Hypothyroidism

SIR,—The letter from Dr. D. C. Evered and Professor R. Hall (17 November, p. 425) throws some light on the statement in their paper (21 July, p. 131) that "the raised level of serum triglyceride concentration is unexplained and has not been reported previously." "Raised" refers to a change after treatment in four patients and not to the difference in mean value between their controls (103 mg/100 ml) and one of their treated groups (150 mg/100 ml). The four patients to whom they refer had serum triglyceride levels between 110 and 140 mg/100 ml, which are not raised above normal, and one cannot tell without some statistical information whether they are different from the pre-treatment values. If there is no significant difference, they have nothing to explain.

In the same issue of the *B.M.J.* there are interesting letters from Drs. Mary J. E. Van Der Vis-Melsen and Jan D. Wiener (p. 419) and from Drs. H. Hedstrand and L. Wide (p. 420) on the possible influence of thyrotrophin (TSH) on blood lipids. Drs. Van

Der Vis-Melsen and Wiener suggest that the observed increase in the serum cholesterol is a direct effect of thyrotrophin-releasing hormone (TRH) or of TSH. There is evidence that TSH itself, rather than TRH, causes serum triglyceride levels to rise.—I am, etc.,

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¹ Fowler, P. B. S., *British Medical Journal*, 1972, 1, 247.

Measles

SIR,—We were interested to read Dr. S. R. Saxena's letter (22 September, p. 632) in response to your leading article (28 July, p. 187) on the pathogenesis of measles. He comments that "despite the advent of measles vaccine this disease remains a challenging problem for the treating doctor, especially in India." A study comparing the mortality and morbidity of measles during 1936 and 1972 was recently undertaken in Glasgow.¹ Dr. Saxena's observations of measles morbidity in Hyderabad, India, during 1964-6 were similar to those made in Glasgow (with similar population size) during 1936.

Mortality due to measles in Scotland started to show a steady fall in the period 1926-40 (from 19.1 per 100,000 population in 1926 to 3.4 per 100,000 in 1940). This was followed by a dramatic improvement (0.1 per 100,000 in 1971). It is likely that the availability of antibiotics after 1940, the establishment of the National Health Service in 1948, and the advent of measles vaccine in 1954, with its subsequent general use in Britain by 1968, may have contributed to the overall decrease in the mortality and morbidity of measles. The decreasing trend of mortality before 1940 may be attributed largely to the alteration in the living style of British society, with improvement of sanitary conditions, better housing, and increasing awareness of health and disease. The belief of the British public in "nuclear family structure" and the voluntary practice of family planning methods have resulted in a gradual decrease in the birth rate over the years. This important factor may have also contributed to the current decrease in the incidence of measles to some extent by introducing fewer susceptible persons into the community.

The isolated reports of mortality and morbidity due to measles from selected centres² (mostly from urban teaching hospitals) in India are often misleading. Only 20% of the population of India live in urban areas. A section of this population live up to the maxim of "where the babies are money ain't." These people, owing to their ignorance and poverty, go to the hospitals only when they are desperately ill. Ironically (to the epidemiologist) these are the only statistics available. The remaining 80% of the population live in rural areas, where the villages are small and isolated. Limited studies of measles in rural India³ have shown that measles is not so severe a problem as in the urban areas. In support of this, mathematical models⁴ have shown that the critical population size required for a measles epidemic to occur is 250,000. Hence measles may exist mainly as an endemic disease in the rural areas.

The pathogenesis of the severity of