

hepatitis and hepatitis-B antigen was shown to be present by both haemagglutination and electrophoresis.

This case cannot, of course, be claimed to provide proof of a causal association between acupuncture and serum hepatitis. The possibility of transfer of infection by an inadequately sterilized needle should, however, be borne in mind.—I am, etc.,

K. K. HUSSAIN

Department of Infectious Diseases,
Neasden Hospital,
London N.W.10

Referees and Rejects

SIR,—The point made by Dr. D. F. Horrobin (27 April, p. 216) on referees and research administrators as barriers to scientific research certainly is topical in small countries where, as pointed out in your leading article (p. 185), personal aspects will come in, often to a dangerous extent. Professor J. M. Tanner (18 May, p. 381) asks for a precise blueprint of a system and I venture to suggest one which at the same time may illustrate some of the problems faced in this connexion by research workers in smaller countries.

(1) Editors should take more personal responsibility in estimating whether a paper may not, for example, require a longer summary than usual or a few pages less than average. As it is, one often feels that strict rules have been laid down to facilitate the running of the journal by clerks. It is true that acceptance of bad papers will in the long run ruin a journal but unjust rejection of a good paper will have its immediate effect on the author who, after all, is more important to research.

(2) Journals should give lists of their referees (for example, on their cover), with more than one expert in each field. This would serve to prevent the possibility that the same men could reject the same paper for more than one journal.

(3) Authors should be permitted to recommend one referee from this list and, if they want, to delete a name in their own case.

(4) Referees should make their remarks in better form than is often the case. Grammatical errors or clumsy constructions in manuscript from foreigners should be marked—for example, with question marks—suggesting that the referee respects the effort it is to present a paper in a language different from the author's own.

(5) Anonymity should extend equally to authors and referees, leaving both sides of the fence guessing. Self-justification is not restricted to authors, who could give their names on separate sheets.

(6) Editors should never at the same time serve as members of granting agencies.

(7) At least 75% of the members of these august bodies should have made contributions to research, and the chairman should belong to this category. Direct appointments by Ministers should not take place and membership should not extend to more than six years.

(8) Members of granting agencies should not be permitted to participate in the discussion of applications from their own institution unless called in for conference, as may be customary for others. It certainly is preferable that members should refrain from applications to their own agency during tenure of membership.

(9) Applicants should, in case of rejection, have access to the verbatim and full comments on their application and should have the opportunity to forward their own remarks and some access to appeal—for example, to experts abroad.

Generally, rules should be laid down to forestall unfortunate developments. It is well known that, not unlike politicians in some Eastern states, many members of the medical profession want to crown a career of influence ("medical politics") with the air of a scientist. If this happens often, the danger

is that scientific research will become a pyramid in each country, and the true scientists will go where freedom is—that is, where research is administered by scientists.

Perhaps I may add that through 38 years I have found referees helpful in nearly all cases, though in most cases there have also been various misunderstandings. The trend, however, is towards some reduction of the former quality and some increase of the latter. The animosity against publishing statistics on man to the same extent as on the mouse has, however, not changed.

I have only once seen an important constructive proposal from a referee. Since this happened with your journal I venture to submit the above comments.—I am, etc.,

JOHANNES CLEMMESSEN
Director, Danish Cancer Registry

Finsen Institute,
Copenhagen

SIR,—Dr. D. F. Horrobin (27 April, p. 216) draws attention to the secrecy and fallibility of the procedures for assessing grants in Britain. New procedures are needed such that the applicant can react rationally to known criticisms, valid or otherwise, instead of having to ponder an unlimited number of conceivable ones. If necessary, subsequent correspondence could be strictly limited.

In the meantime research workers should feel no obligation to justify in detail their research proposals unless, in reciprocal courtesy, the funding agency agrees to justify the contrary view, at least briefly, should that be the outcome of the assessment procedures. Feedback of one sort or another has been in operation for many years in Canada and the United States and elsewhere, hence Professor J. M. Tanner (18 May, p. 381) seems to be incorrect in implying its impracticability.

The Medical Research Council and Department of Health and Social Security, having failed so far to respond constructively to the widespread requests for review of their procedures,^{1,2} should not be surprised if an independent inquiry, as suggested by Professor V. R. Pickles (18 May, p. 382), is eventually set up.—I am, etc.,

J. H. RENWICK

London School of Hygiene and Tropical Medicine,
London W.C.1

- 1 Dixon, B., *New Scientist*, 1974, 61, 522.
- 2 O'Brien, J. R., *Lancet*, 1973, 2, 1323.
- 3 Pickles, V. R., *Lancet*, 1974, 1, 620.
- 4 Renwick, J. H., *Lancet*, 1973, 2, 624.
- 5 Williams, B., *Lancet*, 1973, 2, 798.

Complication of Proximal Gastric Vagotomy

SIR—All surgeons interested in modern gastric surgery will have read with some concern the complication of lesser-curve necrosis after proximal gastric vagotomy described by Mr. J. F. Newcombe (10 March 1973, p. 610) and again by Mr. J. H. Wyllie (8 June 1974, p. 561). However, I hope none will be persuaded to abandon or not to adopt this important advance in gastric surgery.

We must not forget that bilateral selective vagotomy divides the arterial supply of the lesser curve completely from the cardia to the pylorus, while proximal gastric vagotomy preserves its arterial supply for some 10-12 cm above the pylorus. If lesser-curve

necrosis is a complication of vagotomy it must occur more frequently after bilateral selective nerve section than after the proximal gastric operation.

In some 1,000 bilateral selective operations performed between 1957 and 1970 and some 400 proximal vagotomies since 1970 I have never seen this complication and I am sure that others can record similar results.—I am, etc.,

HAROLD BURGE

Charing Cross Hospital (Fulham),
London W.6

Hyperthyroidism and Giant-cell Arteritis

SIR,—Now that immunity is known to be altered in giant-cell arteritis the comparison between this disease and sarcoidosis¹ is closer than was earlier realized. The immune response may account for both the higher incidence of hyperthyroidism in the cases found by Drs. R. D. Thomas and D. N. Croft (25 May, p. 408) and the focal and granulomatous hepatitis, which has occasionally been reported.^{2,3} The systemic reaction satisfactorily explains the anaemia, raised E.S.R., and weight loss, and the immune reaction appears to prolong rather than curtail the inflammation. Giant cells are a feature of both the diseases, the duration of activity of each is similar, and the symptoms of both are controlled by small doses of prednisone. Giant-cell arteritis occurs after middle age, when arteries are more liable to atherosclerosis. The inflammation damages the arteries predominantly, and the lesions elsewhere remain subclinical. The occurrence of the arteritis only in the elderly is unexplained. But in patients whose immunity is already raised microembolism of atheromatous plaques⁴ might cause the focal arteritis. Thyroid biopsies and immune studies in prospective studies of cases of giant-cell arteritis are likely to be interesting. The patients with thyroid or liver involvement might at least show the immune reaction of sarcoidosis.⁵ The arteritic lesions are after all not unlike the granulomas seen at venepuncture sites in some cases of sarcoidosis. Myocardial sarcoidosis is being seen more often now.⁶—I am, etc.,

GERALD A. MACGREGOR

Chilworth,
near Guildford,
Surrey

- 1 MacGregor, G. A., *Lancet*, 1972, 1, 1067.
- 2 Hall, G. H., and Hargreaves, T., *Lancet*, 1972, 2, 48.
- 3 Long, R., and James, R., *Lancet*, 1974, 1, 77.
- 4 Gibbs, P., *Lancet*, 1974, 1, 351.
- 5 Barnes, C. G., *Lancet*, 1974, 1, 459.
- 6 MacGregor, G. A., *Lancet*, 1961, 2, 1160.
- 7 Caspary, E. A., and Field, E. J., *British Medical Journal*, 1971, 2, 143.
- 8 Fawcett, F. J., and Goldberg, M. J., *British Heart Journal*, 1974, 36, 220.

Ischaemic Colitis Due to Myxoedema

SIR,—We think it worth while to record the following case of ischaemic colitis secondary to myxoedema.

A 53-year-old woman presented with habitual constipation, shock, and abdominal distension. Vomiting had produced severe dehydration. Abdominal radiography showed considerable gaseous distension of the large bowel. After treatment with steroids, plasma expanders, and intravenous fluid replacement the blood pressure improved. At laparotomy the transverse colon was dilated and necrotic at the splenic flexure. Hard faeces obstructed the descending colon. The