Correspondence

Letters to the Editor should not exceed 500 words.

Bleeding Peptic Ulcer

SIR,—All will be very grateful for the valuable analysis and appraisal of conservative surgery for bleeding peptic ulceration by Professor J. C. Goligher and his colleagues (14 January, p. 80). Of particular interest is the management of gastric erosions, and everyone must share the anxiety expressed in their paper. In another analysis¹ there was a 12.5% mortality from bleeding erosions. When these are single or few the recommended conservative procedure with suture of the bleeding points may succeed. However, if the problem is one of numerous erosions the management is difficult and perplexing.

In the gastroenterology unit at Frenchay Hospital in 1964–5 133 patients with bleeding peptic ulcer were treated, with an overall mortality of 6.7%. In this series there were 37 cases of bleeding erosions with one death due to coincident haemophilia. Only three came to surgery, and each had a Polya gastrectomy to reduce the size of the bleeding area, together with direct suture of residual, accessible erosions nearer the fundus. All survived, but not without prolonged anxiety owing to continued bleeding needing transfusion for some two to three weeks post-operatively. Clearly, the operative procedure was far from satisfactory. However, on these and other patients we were able to make some observations:

(1) The erosions were not associated with acid secretion. The gastric contents were alkaline (pH 8), and acid pH levels could not be recorded anywhere on gastric mucosa at operation.

(2) The gastric mucus, instead of being diffused, was in the form of large white globules and unable to protect the mucosa.

(3) There was frequent and massive biliary reflux into the stomach.

During 1965 four further patients with multiple erosions required surgery—about 1

in 12 of the patients seen. In view of the observations mentioned, and in particular the finding of massive reflux, a modified operation was done based on the following precepts:

(1) Vagotomy—to anticipate return of acid secretion and possibly to open the gastric vascular shunts.

(2) Hemigastrectomy—done only if this would reduce the size of the bleeding area effectively.

(3) Roux-en-Y anastomosis—to deviate bile away from the stomach.

Two patients (male, 48 years and 52 years) had a vagotomy and Roux-en-Y anastomosis after pyloric section, while two (male, 59 years and 36 years) had superadded hemigastrectomy. All had severe multiple erosions with gross uncontrolled bleeding. In each case there was no further bleeding after 24–48 hours postoperatively. Three patients had a speedy recovery and are very fit, but one patient, the youngest, died after one week from pneumonia and renal failure despite dialysis.

Multiple gastric erosions are not an uncommon cause of severe and prolonged haemorrhage. Apart from those induced by drugs, etc., the cause is not known, although massive biliary reflux may be an important factor (compare role of biliary reflux in chronic gastric ulcer). We have been impressed by the speed of control of the bleeding by vagotomy and biliary deviation and hope to continue this trial for full publication later. Meanwhile we trust that this preliminary communication may help others faced with this very difficult and trying problem.—I am, etc.,

T. J. BUTLER.

Frenchay Hospital,
Bristol.

REFERENCE

- ¹ Capper, W. M., and Buckler, K. G., *Brit. J. Surg.*, 1964, 51, 752.

Radical Bladder Surgery

SIR,—Your leading article on radical bladder surgery (28 January, p. 188) is timely inasmuch as it stresses that there is still no one method that can be applied to all vesical tumours and that neither radiotherapy nor surgery is curative in more than a minority of patients with deeply infiltrating growths (into deep muscle or perivesical tissue).

The article is, however, possibly premature. Some years ago the M.R.C. attempted to organize a clinical trial for the evaluation of various modes of therapy, but because of preconceived ideas it was found not possible to select any group for a clinical trial.

During the last 18 months, in conjunction with centres abroad, we have been conduct-

ing carefully controlled trials on selected clinical groups of patients with infiltrating bladder tumours. These trials aim to evaluate the role of (i) irradiation alone, (ii) surgery alone, or (iii) preoperative irradiation followed by surgery. It will take some time before we are in a position to evaluate the results, not only by survival and function, but also in the light of tissue culture and tritiated thymidine studies of tumour tissue before and after irradiation. So far, we can report that radical surgery four weeks after preoperative supervoltage irradiation to the pelvis (4,000 r in four weeks) is not accompanied by an increased operative mortality. In fact our mortality has recently fallen from 20 to 5%.

When unqualified and dogmatic statements are made, such as "it is now clear that radiotherapy improves the prognosis after surgical excision," the ethics of continuing trials in this field may be questioned and the investigation may have to be abandoned before a definite conclusion can be reached. We would plead for a scientific basis of proof to be available before any claims are made which might jeopardize the success of already well-established clinical trials.—We are, etc.,

D. M. WALLACE.

H. J. G. BLOOM.

Joint Urological Tumour Clinic,
Royal Marsden Hospital,
London S.W.3.

Glycosuria of Pregnancy

SIR,—In his valuable article (28 January, p. 205) Dr. J. Fine suggests it is logical to conclude that the test for urine glucose in pregnancy is a superfluous procedure, and he recommends routine blood-sugar estimations in all multiparae, whether found glycosuric or not.

Probably the most rapidly growing babies I have met have been those artificially fed on sweetened condensed milk—that is, on milk with an exceptionally high sugar content. Many of the largest babies born are offspring of mothers who are prediabetic or diabetic—that is, have an exceptionally high blood-sugar content. The size of the baby at term is an accurate, and much simpler, estimate of the mother's "round the clock" blood sugar than is any single routine laboratory test.

I believe it is logical to conclude that routine blood-sugar estimations are a superfluous procedure in all multiparae, except those who have at term produced large babies.—I am, etc.,

Reading

K. D. SALZMANN.

SIR,—I have read with considerable interest the article by Dr. J. Fine (28 January, p. 205) entitled "Glycosuria of Pregnancy," and while congratulating him on his painstaking work feel obliged to take issue with him on some aspects of his article.

Dr. Fine has demonstrated the previously known fact of the presence of glycosuria in almost 100% of the population at large,¹ and in his present article a similar total finding in pregnant women, which is not very surprising, the difference being that in the former 90% was minimal—that is, 0 to 15 mg./100 ml.—and in the latter 75%, detected only by special biochemical methods, while 10% of the former and 25% of the latter had glycosuria of more than 15 mg./100 ml., usually detected by the Clinistix method. Surely it is these 10% and 25% respectively which contain the vast majority of "chemical" or frank diabetics, and if this be so then the Clinistix method still remains a valid screening procedure, and it is only these lower percentages that would be submitted to glucose-tolerance tests. It follows from the above that the objections Dr. Fine raises to the use of Clinistix as a