would be best fitted to take on this enormous task. I do not think that this is a question which can be answered at the moment, but it certainly demands a great deal of attention, not only from the medical profession but from all sectors of society, especially the general public, many of whom will be directly affected by the outcome of the debate (if and when it takes place).

Lest my criticism seems wholly destructive I must make it clear that I believe that the treatment of the mentally ill is the most important problem in modern medical practice and one which demands all our attention. I also believe, however, that it cannot be solved by increasing the number of psychiatrists.—I am, etc.,

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SIR,—Few will disagree that the hospital care of the mentally subnormal should be a multidisciplinary activity, involving the various professions named in your leading article (24 February, p. 435). However, to suggest as you, Sir, appear to do, that the answer to the present shortage of suitable qualified medical staff is for teachers, psychologists, and social workers to be invited to fill the gap, is, I submit, both extremely naive as a solution and misleading in implying that these professions are not already involved in looking after the mentally subnormal in hospital along with members of the supplementary medical profession—although how we ever manage to persuade the latter to work in hospitals when local authorities are able to offer them so much better salaries and conditions of service never ceases to amaze me.

As local authority residential provision for the mentally subnormal increases, those requiring hospital care will be those who are most severely physically and mentally handicapped or disturbed in their behaviour. Whatever the contribution of other professions to their care, highly skilled medical staff will still be required to look after them. To fill the present gap the number of senior registrar posts in mental subnormality should be increased in the hope of persuading registrars in general psychiatry to accept training in this subspecialty at this level rather than, as so often happens at present, applying for and, regrettably in my view, being appointed to consultant posts in mental subnormality without adequate experience.

I suggest that Brook's findings¹ that none of the trainees in his survey would have transferred to subnormality had they failed to obtain a consultant post in general psychiatry may reflect the lack of adequate training in subnormality at the undergraduate and postgraduate levels and the fact that, at present, there is no chair in mental subnormality in the British Isles. May I ask that you, Sir, give your support to remedying this deficiency and that referred to in the previous paragraph rather than pursuing the surrender of the care of the mentally subnormal to non-medical professions, vital as they are as members of the multidisciplinary team.—I am, etc.,

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¹ Brook, C. P. B., *British Journal of Medical Education*, 1972, 6, 190.

Postgastrectomy Retroanastomotic Hernia

SIR,—In view of the recrudescence of the operation of partial gastrectomy for duodenal ulcer, I think the letter from Mr. J. T. Hill (13 January, p. 116) is quite important. After partial gastrectomy with gastrojejunal anastomosis one can anastomose the proximal loop to the lesser curve or to the greater curve. If the anastomosis is to the greater curve (Moynihan) then a long afferent loop is of no great consequence, though it is undesirable. If to the lesser curve, then a long afferent loop such as has been often recommended (8 in (20 cm) or more) can be dangerous and produce the complication which Dr. Hill mentions—namely, the excess afferent loop may strangulate behind its own mesentery. It may even distend enough to perforate, and the complication may occur in the postoperative period or many years later.¹

One of the most important technical points in the prevention of herniation behind the mesentery after antecolic partial gastrectomy is a tip given by Moynihan in the early years of this century—namely, at the end of antecolic operation, to draw the colon to the right, so that the afferent loop lies well up under the splenic flexure. Following the antecolic operation the relation of the colon to the anastomosis at the termination of the operation appears to be permanent, and so it is most important to place the colon in the right position at the end of the operation and not leave it drooping on either side of the antecolic loop.

With regard to the precise complication mentioned by Dr. Hill, many surgeons have written to me mentioning this problem and in my own series, in which we used an 8 in antecolic loop, we found that roughly one in every 200 would, within the first few years, develop the type of obstruction mentioned.

In prevention, Markowitz² has suggested that the space should be closed routinely. This is difficult and almost impossible to do perfectly. A very simple answer to this problem is, first, to draw the colon to the right at the end of the operation and, second, to make the afferent loop short. We make it only 3 in (8 cm) long and since doing this in well over 1,000 cases I have never seen another case of acute afferent loop obstruction. I am sure this is a much more practical method of prevention than to try the very difficult task of closing the retroanastomotic space.—I am, etc.,

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¹ Tanner, N. C., *Postgraduate Medical Journal*, 1954, 30, 448.
² Markowitz, A. M., *Surgery*, 1961, 49, 185.

Fatality after Highly Selective Vagotomy

SIR,—In recent years there has been increasing interest in the operation of highly selective vagotomy for duodenal ulcer. In common with many surgeons, I believe this to be in general a safe and effective operation, but I wish to report a recent fatality from avascular necrosis of the lesser curve following this procedure.

The patient was a young man of 34 with a long history of duodenal ulcer. In the absence of pyloric stenosis a highly selective vagotomy was carried out in the standard manner without any operative difficulty. His

initial progress was satisfactory, but on the fifth day he developed paralytic ileus, the cause of which could not be ascertained. He was treated conservatively but by the seventh day his condition had sharply deteriorated and it was clear that he had an established peritonitis.

At laparotomy there was a large perforation some 2 cm in diameter on the lesser curve of the stomach near its junction with the oesophagus. Such a perforation could not conceivably have been produced inadvertently at the initial operation. It would seem much more probable that it was due to the devascularization of the lesser curve that necessarily accompanies this procedure. Normally this is adequately compensated by the numerous alternative sources of blood that the stomach enjoys, but evidently this was not so in this case. The perforation was closed but the patient's condition remained critical. Twelve days after the second operation he again showed all the signs of peritonitis and a further laparotomy was carried out. The suture line was found to have broken down completely. The defect in the lesser curve was again sutured, but he never recovered from this procedure and eight days later he died.

At necropsy the findings were consistent with a localized necrosis of the stomach immediately distal to the cardia. Although the suture line was intact there was no sign of healing.—I am, etc.,

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Care of the Dying

SIR,—I was interested to read Dr. W. R. Moore's letter (10 February, p. 353) on terminal care. I warmly agree with most of it.

I do not think any of us would argue that the support of their own doctor in combination with good nursing care and other help would be the choice of most dying patients and their families. But surely we all at times call in consultants for help and advice. In the care of the dying, as in other branches of medicine, there are times when all of us are glad of discussion with others more conversant with some particular problem. Our patients have benefited from the experience of specialists without any loss of confidence in their own medical advisers. Collaboration, not take-overs, is the secret of good terminal care and there should be no question of the general practitioner being superseded.

At the D.H.S.S. symposium (6 January, p. 29) the need for different approaches was discussed and the wide differences in care and practice and thence the needs of the patients concerned were noted. It would seem to me that there is ample room for all the various approaches (of which Dr. Moore's must indeed have high priority) in meeting the needs of dying patients. There is little doubt that all possible sources of help will be needed by them—general practitioner, hospital, consultative—and that the more we all work together for the good of our patients the better care they will have.—I am, etc.,

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