CORRESPONDENCE

Advantages and disadvantages of highly selective vagotomy	
D S Hopton, FRCS, and others.....	149
Long-stay mental hospital population	
M Silverman, FRCPsych; W A Heaton-Ward, FRCPsych.....	149
Pharmacogenic shoplifting?	
J Todd, MRCPsych.....	150
Selective induction of labour	
P W Howie, MD, and others.....	150
Joint Committee on Higher Medical Training: enrolment and accreditation	
J W Crofton, PRCPED.....	150
Vesicoureteral reflux and its familial distribution	
P G Ransley, FRCS.....	151
Carrier solutions for low-level intravenous insulin infusion	
P H Sönksen, MD; M Burton, MA.....	151
Laboratory diagnosis of malaria	
G H Ree, MRCPED, and P G Sargeant, AIMLT.....	152
Dependence on antiparkinsonian drugs	
P F Marriott, MANZCP.....	152
How much can ancillaries take over?	
T B Boulton, FFARCS.....	152
SLE precipitated by antibiotics in Sørensen's syndrome	
J R Sewell, MRCP.....	152

Acanthamoeba meningoencephalitis in Britain	
J L Griffin, PHD.....	153
"Corrected" calcium concept	
R B Payne, MD, MRCPATH, and others; D Webster, FRIC.....	153
Changing status of doctors in Finland	
P Kekki, MD.....	154
Prophylactic treatment of postgonococcal urethritis	
W Fowler, MD.....	154
Teething myths	
Margaret H Seward, FDSRCS.....	155
Steroids and common skin diseases	
K Haeger, MD.....	155
Diagnosis of pericardial effusion by echocardiography	
C G C MacArthur, MRCP, and A J Rees, MRCP.....	155
Gastric ulcer—short-term healing and long-term response	
D W Piper, FRACP, and others.....	155
Cooking the Christmas turkey	
D L Carr-Locke, MRCP.....	155
Medicine in the seventies—attitudes and expectations	
A C L Mackie.....	155
Academic general practice	
D H Glynn, MB.....	156

RHA or AHA?	
D Zuck, FFARCS.....	156
Consultants' ballot	
J B Kinmonth, FRCS.....	156
Industrial action	
P M Vicary, MB.....	156
Admission of GPs to restricted areas	
J R Butler, MA, and R Knight, BSC.....	156
Entry to hospital practitioner grade	
R D Rowlands, FRCS.....	157
Points from letters	
Enteric-coated aspirin overdose and gastric perforation (R J Farrand); Medical tales of captivity (B Williams); Pilonidal sinus (D H Patey); Cooking the Christmas sausage (P G Shute); James Joyce—a case history (F R P Walsh); Better medical writing (J S Bradshaw); Cancer risks from hormone treatment (S M Barlow); A "Guinness" for gynaecology (R W Taylor and I L C Fergusson); Smoking in the elderly (L M Johnston); Solving staffing problems (J M Ioannou); Private practice and the NHS (C S Good); Medical musicians (I Friedmann); Retention of foreign body in the stomach (P H Daniels and others); Junior hospital staff contract (R M Bark).....	157

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Advantages and disadvantages of highly selective vagotomy

SIR,—We read with great interest Professor D Johnston's informative paper on highly selective vagotomy (HSV) (6 December, p 545). In common with most other papers so far published about this operation the conclusions are favourable to an extent that prompts a word of caution.

A randomised comparison of HSV and truncal vagotomy with pyloroplasty (TVP) was started in York in April 1973. A strict protocol has been followed which selects for consideration only those patients with proved duodenal ulceration and rejects patients in whom there is other disease. At operation, after inspecting the pylorus, the surgeon decides whether either operation is feasible. At this point the patient is either rejected from the study or the choice of operation is decided by opening an envelope containing a randomised card.

During the first 29 months (16 April 1973 to 29 September 1975) 142 patients were considered, 50 patients rejected, and 92 patients entered into the study. The reasons for rejecting patients were as follows.

Pyloric stenosis	28
Technical difficulty experienced or expected	8
from HSV	5
Biliary disease	3
Gastric ulcer	6
Other reasons	

The Visick grades in 78 patients who have been followed up for at least one year are presented in the table. One patient died after

HSV because of lesser curve necrosis and one other patient developed this grave complication and survived.

	Visick grade				Total
	I	II	III	IV	
HSV	15	5	3	2	25
TVP	9	6	5	1	21
Rejects (TVP or TV and gastroenterostomy)	16	8	8	0	32

Our impressions at this interim stage in the study are as follows. (1) A considerable proportion of our patients have been considered not to be suitable for HSV alone because of operative problems, and some were rejected because they were unsuitable for pyloroplasty. (2) HSV is certainly a more difficult operation and takes longer to do than truncal vagotomy and drainage. (3) HSV may be more dangerous to the patient than truncal vagotomy with pyloroplasty or gastroenterostomy. (4) The Visick grades after operation are no better than for other operations for duodenal ulcer.

We consider that it is important to emphasise that HSV can be very difficult in obese patients. If it is necessary to add a gastric drainage procedure to HSV, then this eliminates one of the main advantages claimed for the operation. We do not think that properly randomised studies have been conducted for long enough on sufficient numbers of patients to assess the operation

fully. Surgeons who contemplate changing their practice to include HSV should consider that the operation has not yet been proved to be the best.

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Long-stay mental hospital population

SIR,—I write concerning the two papers dealing with the outlook for long-stay mental hospital patients by Dr Thomas Bewley and others (20 December, p 671) and Dr Eamonn Fottrell and others (p 675). The former authors challenge the Department of Health's view¹ that "when all the new general hospital departments to serve the area are in operation and only a comparatively small number of patients remain in the mental hospital, it should become possible to close the mental hospital by transferring these remaining patients to other appropriate hospitals." They refer to "the premise that most mental illness can be treated suitably in a general hospital" and suggest that this premise is probably incorrect.

Great play is frequently made of the fact that, as yet, not a single mental hospital has been closed. There is, however, another side of the story which, in spite of frequent publications,^{2,5} is persistently overlooked. This is the fact that in many parts of the north-western region large areas are already being served by psychiatric services centred ex-