specialist psychiatric advice is necessary for all self-poisoned patients, we should have found that the patients assessed by the medical teams had fared less well than those assessed by psychiatrists. But... there was no significant difference between the groups in the incidence of relapse during the trial." They considered that, "a specialist psychiatric training is not essential for the purpose of assessing suicidal risk" and conclude that there is "a strong case for amending the recommendation in the Hill Report so that physicians may decide in each case of self-poisoning whether a psychiatric opinion is necessary."

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If I Had . . .

If I had carcinoma of the middle third of the rectum

H A F DUDLEY

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Background

Surgically, there has hardly been a more extensively studied tumour than carcinoma of the rectum. We know that it can be detected relatively early (though not in the biological sense) because of its obvious symptoms of bleeding, mucus discharge, and tenesmus. Spread occurs distally and laterally, as well as in the more conventional way to lymph nodes on the superior rectal vessels in the mesentery of the rectosigmoid, and thus by the portal venous system to the liver. The centrifugal nature of spread makes it more difficult to cure the more distal is the growth,¹ or once it is through the full thickness of the rectal wall. These facts have led to the development of the standard operation of abdominoperineal excision of the rectum for middle and distal third growths, which removes en bloc the rectum, perirectal tissues, anal canal, and perineal skin in addition to the rectosigmoid and its lymphatic drainage.

Surgical skill has brought this operation to a stage where the resectability rate is 98%² and the mortality rate of the order of 2.5%.³ Furthermore, surgery does cure the disease. For tumours in the wall only (Dukes's A) the five-year survival rate is up to 90%; for those with transmural spread (Dukes's B), somewhat less but yet remarkably good (71%); and even in the presence of lymph node metastases (Dukes's C), though it is less again, a respectable 38%. In addition, the operation, by eliminating the fungating or ulcerating eccentric fixed rectal bolus of tumour, abolishes the distressing problem of rectal discharge, bleeding, and tenesmus. As an aside, it should be recorded that this cannot be achieved with proximal colostomy alone: one of my many abiding bad memories is of McNeil Dixon, Glasgow's illuminatory professor of moral philosophy, being subjected to this procedure and thereafter quietly and calmly committing suicide.

The price of abdominoperineal resection is a permanent left iliac colostomy, an appreciable incidence of problems of emptying the urinary bladder, and, in men, a 30-50% incidence of sexual dysfunction up to and including impotence.^{4 5} Scarce wonder that Devlin and his colleagues⁶—whose contribution to the subject has been both original and heterodox—found many individuals severely isolated, depressed, and needing to use a variety of "deviant" mechanisms to hide or contain their problem. An example of embarrassment would well be the patient who said, "How would you like to be standing talking to an attractive woman at a cocktail party conscious of the fact that your bowels are emptying—perhaps audibly—into a point just above the level of your left hand trouser pocket."

COLOSTOMY MANAGEMENT

Colostomy management has advanced tremendously since 30 years ago, when, as a resident, I was advising my patients to cover the stoma with sheets from the *Scotsman* or *Edinburgh Evening News* and hope for the best. In spite of what I may say later about organisations in relation to 'ostomy care, pressure by concerned patients and a few thinking surgeons has produced well-sealed and thus relatively odour-proof appliances which remove the stigma of smell if not of noise. The American alternative of irrigation, though possibly marginally more time-consuming, can keep the large bowel empty and permit the patient to be virtually without appliance or embarrassment. Clearly, however, many feel totally insecure with a colostomy, even though to us it appears quite satisfactory.

The alternatives to abdominoperineal excision and left iliac colostomy are four: panproctocolectomy and ileostomy; local surgical resection with reconstruction^{7 8}; the analogous if not identical procedure of in situ destruction by diathermy or cryosurgery; and some type of reconstructive procedure after conventional radical excision. The first I will return to later. The second and third have the chief potential advantage of much less pelvic dissection and therefore, perhaps (and it is a big perhaps), less disturbance of bladder and sexual function. They have certainly not been subject to the same degree of critical

Academic Surgical Unit, St Mary's Hospital, London W2

H A F DUDLEY, FRCS, director

analysis that has been applied to more radical procedures; furthermore, results in relation to cure are not established. Logically, lesions which are truly Dukes's A *must* be cured by local excision,⁹ but how does one establish for a patient that he or she is in that category?

The fourth alternative carries most of the damaging disadvantages of abdominoperineal excision, but can result in a normal faecal stream, and oddly enough in men is not associated with quite the same risk of impotence. Whether or not defecation is normal depends on the level of resection, but even the total absence of the rectum is probably compatible with continence, so that other factors such as the state of the perineal muscles, the amount of extrarectal dissection (for there is convincing evidence that sensors lie outside the rectal wall¹⁰), and the patient's ability to put up with an initial few months of incontinence without a decline in morale may well be important. The outlook for cure after restorative resection is probably about the same as for abdominoperineal excision,^{2, 3, 11} but, again, hard information is lacking, especially about the distal third of the rectum. Restorative resection in the 'fifties or 'sixties—the experience on which rests the case for cure—was reserved for patients who "looked as though they would do well": mobile tumours at the proximal end of the extraperitoneal rectum; fitness for surgery, and at laparotomy no macroscopic metastases to the lymph nodes. In addition, subjective factors in the attitude of the surgeon also probably played a considerable part in case selection. Thus, the present swing towards preservation of a perineal faecal stream by extending the indications for restorative resection will test some of the dogma derived from the 'sixties.

Conventionally, the surgeon feels it necessary to have a clear distal margin of 4 cm beyond macroscopic growth to avoid local recurrence, but this figure, though it is enshrined in a number of pathological studies,¹² is somewhat arbitrary.

If I had . . .

And so, if I had a cancer of the mid-third of the rectum which I hoped was Dukes's A or B but had to fear was Dukes's C, what would I do? I am absolutely certain—and this I am sure will bring the wrath of most colorectal surgeons on my head, but no matter—I would not have an abdominoperineal resection with a colostomy. However managed, however much we delude ourselves, a permanent potentially incontinent abdominal anus is an affront difficult to bear, so that I marvel that we and our patients have put up with it so long. It says much for the social indifference of the one and the social fortitude of the other.

Given my combination of rational and emotional antagonism to a colostomy, what would I have? If the surgeon (carefully selected, of course) thought it feasible, I would have as low an anterior resection as possible, asking him to preserve the posterior and lateral fascia of the pelvic wall as far as he could because my fast declining virility is transmitted through there and, though I want above all to live, I do not think a radical extra-fascial dissection is going to make much difference except to the comfort and dignity of my dying days. If he can reconstruct, good luck to him and good hope for me. I would not press him to ensure an arbitrary 4 cm of bowel distal to the tumour edge. I can, with appropriate techniques,^{13, 14} hope for a very low incidence of complications from a properly performed anastomosis deep in the pelvis and, more recently, there is the prospect of either an endoanal procedure,¹⁵ or even perhaps some clever stapling manoeuvre. I may be initially incontinent, but I am prepared to work hard at my perineal muscles to overcome this. After all, I can remember—like many others I suspect—the frequent times in the Far East when faecal continence was maintained only by determined perineal contraction against the advancing tide of cholera-like stool. We have underestimated the capability of the trained external sphincter. Though I agree that in normal people the internal sphincter is of paramount importance and that some signal to the conscious mind is a

necessary preliminary to external sphincter contraction, the relation between the two is not clearly established and would repay further study.

If my surgeon thinks reconstruction impossible, I would opt for an abdominoperineal excision with a total colectomy and ileostomy. Good God, most people would say, the man is mad. But there is method in my insanity. Well fashioned, I think day-to-day management of an ileostomy is easier than a colostomy. There is no smell and, because of the emulsifying action of residual bile, the stoma does not blow off to anything like the same extent. Patients with ileostomies are always said to be better rehabilitated because of their age: in my view it is also because of their operation. Ileostomists have abandoned defecation entirely: they do not have the abnormal defecation of the colostomy patient which may cause so much distress.⁶ Ileostomy effluent is unpleasant, but it is not faeces and this in my view gives a different quality to the lifestyle of the patient. Moreover, it is said that a transverse myotomy¹⁶ of an ileostomy will better the chances still further of having a quiet stoma, though controlled studies of this have not been made and as I see them my patients with ileostomies do not have flatus problems (but have I asked hard enough?)

Finally, to be rid of my large bowel, which through genetic or environmental factors has already let me down by producing a cancer, will reduce the small (10%) chance of a metachronous growth.

CONTINENT ILEOSTOMY

Would I want to jump on the bandwagon of a continent ileostomy?¹⁷ I doubt it. It is a most ingenious technique, but it has a highish failure rate and a considerable incidence of reoperation. More fundamentally, though I concede that when it works it is marvellous, it seems to me to be flying in the face of nature to ask the ileum to act as a storage organ.

Why not a colostomy and a magnetic plug?^{18, 19} Again, I will concede that success is real success, but it is limited and until we can come up with a more tractable device it is not for me. Lastly, why not colostomy and irrigation, which keeps the large bowel empty? It works—no doubt about it—and has appreciably altered the lives of at least two of my younger patients. But culturally it is not for me. I just do not want to see myself as a glorified flushing lavatory in reverse, however effective this may be. I suspect that many others would share my view.

By omission I have condemned for myself local destruction of the tumour or local surgery. This may be wrong, but I see cancer as an invader and want to be as sure as possible it is out of my body. Biologically old-fashioned maybe, but surgical ablation is the only thing that can cure radioresistant solid tumours which are other than in situ. Lastly, I have not mentioned what I would want if I was found to have liver or other distant metastases. This is simply because I do not know: the prospect of a length of life that I can see in defined terms as distinct from the random statistical chance by which we mostly plan our future is too difficult for me to contemplate; only by being really in that condition could I pronounce.

Whether or not I had reconstruction or ileostomy, resection for cure or resection for palliation, I would want to be left alone by the professionals. In the case of reconstruction, follow-up is going to tell my surgeon only that I am ill or well—not curable or incurable. I do not want to know if my carcino-embryonic antigen concentration is starting to rise, and thus again have a term put on my survival. I know that it is wrong, but I cannot escape it. For those with stomas I concede that 'ostomy associations are good places for mutual handwringing and device swapping, but there is more than a measure of unhealthy introspection and even stoma therapists need to know more than they tend to admit when to back off and leave patients to their own devices (no pun intended). I can hear, as I write, the thundering hordes of orthodoxy about to override me and point out what a vast amount of good has been done by both

associations and therapists. Agreed, but that is almost entirely because of our past surgical and nursing sins. Doctors, or nurses, still need a one-to-one relationship with their stoma patients, and that is what I would look for. This apart, however, it is (as with breast surgery in women) just a long haul back to an acceptable body image and a realisation of the limitations that the controlled violence of radical surgery is likely to impose.

Envoi

Men make their own history, said Karl Marx, but they do not make it under circumstances chosen by themselves.²⁰ In saying what I would hope for should I have cancer of the distal third of the rectum, I reflect my upbringing, social values, prejudices, and rank irrationality. Nevertheless, I have tried as far as possible to give documented reasons for my choice to show that through the fog of emotion the dim light of accumulated experience and constructive thought can, to a degree, shine.

Mr L P Fielding helped greatly with discussion of some of the matters contained in this paper.

Which insect repellent should children apply to their skin for protection against insect bites when on holiday in tropical climates? Many return with septic sores as a result of infected insect bites.

If the question refers to bites caused by mosquitoes, gnats, midges, and flies there is still no wonder preparation. Ideally, an insect repellent should remain effective for a prolonged time and neither irritate nor sensitise the skin. Most effective commercial preparations contain dimethyl phthalate, diethyl toluamide, 3-ethyl-hexanediol-1,3, or indalone. All are available in creams or lotions that should be applied 3-4 hourly; care should be taken to avoid the eyes. Dibutyl phthalate is harmless to clothes and resists washing better than dimethyl phthalate. When rubbed into clothes it may give protection for two weeks.

An 18-year-old girl who was on the contraceptive pill developed a malignant melanoma on her leg. This was removed by wide excision. She said the mole had grown while she was on the pill. She is now well; is there any contraindication to prescribing the contraceptive pill now, one year after removal of the malignant melanoma?

The widely quoted hazards of pregnancy in malignant melanoma are based on a few anecdotal observations and are not supported by any critical evidence. Furthermore, there is no evidence of harm from the contraceptive pill. Prognosis in primary cutaneous malignant melanoma is closely related to the depth of invasion of the cutis. If the primary tumour was deeply invasive then the probability of recurrent disease is high, and pregnancy should clearly be avoided for several years. If it was a superficial tumour the prognosis is excellent. In either case there is no contraindication to the use of the pill.

Can continued physical and mental stress extending over several years precipitate a crisis in a leukaemic patient and lead to death?

If the questioner means a blast crisis in a patient with chronic myelocytic leukaemia (CML) then the answer is almost certainly that continued physical and mental stress, whether immediate or extending over several years, is highly unlikely to precipitate such a crisis. The most likely metabolic changes due to prolonged continued physical and mental stress are adrenocortical changes that may extend to partial or complete suppression of adrenocortical hormones. These do have an influence on acute lymphoblastic leukaemia; but whether physical and mental stresses are likely to negate the drug control of chronic myelocytic leukaemia is, so far as I am aware, quite unknown. Since, however, prednisone has no influence on the development of the disease, chronic physical and mental stresses are most unlikely to influence its course.

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Is there any basis for the statement that for every pound a person is overweight his life expectancy falls by 1%?

This broad generalisation is probably an overestimate; it would mean that a man of 25 who was 200 lb (90.6 kg) instead of an ideal 150 lb (68 kg) (and categorised as moderately obese) would have his life expectancy reduced by a half. The effect of obesity on an individual depends on its cause and duration as much as its amount, and also on whether associated diseases such as diabetes and hyperlipidaemia are present. Life assurance tables deal with "excess mortality" (expressed as the percentage by which the deaths in a group exceed those in a control group) rather than "life expectancy." Their figures show no increase in mortality until overweight exceeds 10-15%. If a person is 30% overweight the excess mortality is 42% for men aged 40-69 and 36% for women.

Which of the various regimens advocated has the highest cure rate for uropharyngeal gonorrhoea?

Various treatment schedules have been advocated, and procaine penicillin G 4.8 million units intramuscularly, preceded by probenecid 1.0 g by mouth in a single dose, or tetracycline hydrochloride 1.5 g by mouth followed by 500 mg by mouth four times daily for four days have been effective.^{1,2} Both spectinomycin and the ampicillin-probenecid regimens have resulted in unacceptable treatment failures.³ It has been suggested that oropharyngeal gonorrhoea does not need any treatment as it usually clears up spontaneously. Two new monographs on gonorrhoea give an up-to-date and detailed account of the problem.^{4,5}

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Is the progesterone-only pill a reasonable alternative to the combined pill in a woman aged over 35? What are the contraindications, if any?

The progesterone-only pill would be reasonable in such a patient. The risk of thromboembolic complications¹ might be less but the pregnancy rate could be greater than with the combined preparations, say, 2-3 per 100 woman years compared with about 1 per 100 woman years. Cycle control may also be less reliable. The same contraindications apply as with the combined pill.

¹ Newton, J R, in *Contemporary Obstetrics and Gynaecology*, ed G V P Chamberlain. London, Northwood Publications, 1977.