and remission rates therefore relate only to patients who achieved remission. Since patients were not uniformly notified to the trial co-ordinating centre at the time of first diagnosis we cannot give the survival or disease-free periods of the original population of patients. Nevertheless, of the patients in the present study whose remission was successfully induced with MVPP, 84% (95% confidence interval 76-90%) were alive 5 years after randomisation to the two maintenance regimens. This and the observation that the relapse rates and death rates of patients in the trial declined significantly with time after randomisation suggest that a high proportion of patients who did not relapse within two years of starting maintenance treatment may have been "cured."

Data from the participating centres were collected by Mrs Catherine Harwood. The working party was disbanded in December 1975.

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Transurethral resection of large prostates

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Summary and conclusions

A total of 102 men (mean age 70) underwent transurethral resection of the prostate. The weight of the resected prostate ranged from 40 to 152 g. Two deaths occurred in patients aged 85 and 92 years, both of whom were generally unfit. The average postoperative stay in hospital was 8.3 days.

The proportions of patients with incontinence, infection, and stricture were similar to those in other series of resections and open prostatectomies, suggesting that resection of the larger prostate is safe and an acceptable alternative to an open operation.

Introduction

Prostatic adenomas of small or average size may be removed by adequately trained staff as safely and effectively by the transurethral route as by open operation.¹ The superiority of transurethral resection in terms of the length of stay in hospital and degree of discomfort to the patient is a strong argument in favour of training and employing more specialist urologists.² Despite the increasing popularity of transurethral resection, however, particularly large prostates are still assumed to be better dealt with by an open operation, partly because of the tedium and difficulty of doing a long resection but also for fear of greater complications postoperatively.

To see whether larger prostates may be equally well resected we analysed a consecutive series of 102 transurethral resections of benign prostates weighing 40 g or more.

Patients and methods

We studied 102 patients—that is, all those in whom one of us (RHW) resected 40 g or more during April 1971 to March 1976. Their mean age was 70 years; table I shows the age distribution. The patients were graded according to their preoperative fitness as follows.¹ Grade 1: fit men aged under 70 years with no known cardiovascular or respiratory disease and not diabetic. Grade 2: men aged 71-80 years and younger men with diabetes, hypertension, or chronic lung disease; also those with a history of myocardial infarction or cerebrovascular accident more than six months previously. Grade 3: men aged over 80 years or very unfit, and those with recent myocardial infarction or cerebrovascular accident. Table II shows the distribution of the patients between these three categories.

TABLE I—Age distribution of all 102 patients studied

Age (years)	..	..	..	..	50-	60-	70-	80-	90-100
No of patients	..	..	..	..	11	42	37	10	2

TABLE II—Classification of patients as grade 1, 2, or 3 according to preoperative medical state

Clinical grade	..	..	..	..	..	..	1	2	3
No of patients	..	..	..	..	..	..	40	41	21

Most of the operations in this series were performed under general anaesthesia; a few patients had a spinal anaesthetic. The instrument used was a 26F Thackray or Storz loop resectoscope; if the urethra was tight for this an Otis internal urethrotomy was performed. In all cases we believed that all adenomatous prostatic tissue had been removed.

Most of the resections were of prostates weighing 40-60 g, but several were considerably larger. Table III shows the distribution of

TABLE III—Distribution of weights of resected prostates

Weight (g)	..	40-	50-	60-	70-	80-	90-	100-	110-	120-	130-	140-	150-	160
No of patients	40	34	10	5	5	6	1							1

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the weights resected. The average rate of resection was 1.01 g/min with an average operating time of 58 minutes. The average volume of blood transfused per patient was 1.9 units, but 25 patients required no transfusion. Postoperatively a 22F three-way catheter was used and the bladder irrigated with saline until the bleeding had stopped.

Results

Of the 102 patients, two died in the postoperative period. Both were in category 3 of preoperative fitness. One was an 85-year-old diabetic with a badly ischaemic leg, the other a 92-year-old man in whom a fat embolus was diagnosed post mortem. This was believed to have occurred after the prostatic capsule was perforated.

Eleven patients had urinary infections around the time of the operation and nine had positive urine cultures towards the end of the hospital stay. All infections were treated with appropriate chemotherapy. Throughout the period under review the policy was to remove the catheter on the fourth postoperative morning. In 17 patients the catheter was removed at some other time, the average being 5.6 days postoperatively. Although the average time spent in hospital after operation was 8.3 days, 21 patients were discharged on the sixth day. All patients were seen in the outpatient department one and four months after their operation. They were then discharged if symptom free but kept under review if any problems were apparent.

Ninety patients reported that they had good control of their urine with no dribbling at any time and were thus classified as having good continence. Nine patients, whose basic control was good but who suffered occasional dribbling, enuresis, or similar symptoms, were classified as having fair continence. Three patients were frankly incontinent: one was acceptably dry at 18 months, but the other two continued to need incontinence padding or an appliance.

It was our routine practice not to pass urethral sounds at the follow-up visits unless the patient complained that his stream was poor. Four patients, however, had developed urethral strictures and required between two and six dilatations. All patients had a mid-stream specimen of urine taken at four months and six had an infection, the offending organisms being mainly coliforms or proteus.

Discussion

Once a man with benign prostatic hypertrophy has developed appreciable bladder outflow obstruction giving episodes of acute retention or retention with overflow incontinence surgical intervention is necessary. The choice is permanent catheterisation or an operation. An operation is preferable provided it can be done safely because it offers a permanent cure in most cases, whereas an indwelling catheter represents a permanent source of inconvenience and potential danger.

The advantage of transurethral resection is that virtually nobody is too frail to withstand it, particularly with the increasing use of regional anaesthesia. We have found that the state of many patients on preoperative anaesthetic assessment is such that they would be fit for a transurethral resection but not for an open operation. Those who undergo resection can leave hospital more quickly.² A patient whose bladder outflow obstruction is due to a large prostate need not be excluded from the benefits of transurethral resection. He may be operated on within a perfectly acceptable margin of safety and will not be exposed to any greater risk of developing a stricture or becoming incontinent. We believe that the results in this group of men, many of whom were elderly and infirm, bear this out.

The first 17 patients in the series were under the care of either Mr G C Tresidder or Professor J P Blandy at The London Hospital, and we are grateful for their permission to report these cases.

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Prevalence of facial acne vulgaris in late adolescence and in adults

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Summary and conclusions

A survey of 1066 healthy women and 1089 healthy men aged 18-70 years, performed to determine the prevalence of facial acne, showed that clinical acne was not confined to adolescents. Though it was more prevalent among men than women at 18, beyond the age of 23 clinical acne was more prevalent among women as the prevalence in men gradually declined. At 40-49 years 3% of men and 5% of women still had definite, albeit mild, clinical acne, and at 50-59 years 6% of men and 8% of women had physiological acne.

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The surprisingly high prevalence of acne in adults may be related to antibiotic treatment or, in women, to the use of oral contraceptives or cosmetics, though this survey did not study their influence. Further studies in different populations are needed to establish the prevalence of acne in the community, and its distribution.

Introduction

Over the last few years we have seen an increasing number of patients aged 18 years and over with acne. This might reflect either an increasing awareness of this department's interest in acne or a genuine increase in the prevalence and severity of the disorder. An increase in prevalence might result from treatment with long-term antibiotics or, in women, from the use of cosmetics,¹ or certain types of oral contraceptives.

Information on the prevalence of acne in the pre-antibiotic era is limited,² so we cannot assess the influence of antibiotics. Pathogenic factors in patients with acne aged 18 years and above, such as the sebum excretion rate,³ surface bacteria,⁵ and surface lipid composition,⁶ have also been discussed, but there is no precise information about the prevalence of acne or the age at