specialized experts already working in their fields.—I am, etc.,

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Review of the Abortion Act

SIR,—The B.M.A. Committee, named by the Board of Science and approved by the Council, was initially called to see whether there was a case for re-investigation of the working of the Abortion Act. The initial committee which made the recommendation was representative of different geographical areas of the country and of different skills and opinions, including those with different religious views. The findings of the Committee were approved by Council and the Committee is to have further representatives added to prepare evidence to submit to Mrs. Justice Lane's Committee. Council were well aware of the opinion expressed by Dr. A. O. Diver (15 May, p. 470) but were satisfied as to the impartiality and the capability of the chairman.

Finally, Professor Donald offered to resign but Council did not accept and asked him to continue as chairman of the Committee to give evidence.—I am, etc.,

R. E. TUNBRIDGE

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Small Bowel Fistula treated with Low-residue Diet

SIR,—I wish to report the successful treatment of an extensive small-bowel fistula due to carcinomatous infiltration using a synthetic low-residue diet. The patient, a man of 43, had been admitted to hospital in March 1968 with peritonitis. Laparotomy revealed a perforated carcinoma of the caecum, and a right hemicolectomy was performed. Histology showed a mucus-secreting adenocarcinoma. Postoperatively he developed an incisional hernia and latterly two nodules in the scar, but otherwise he remained well for 18 months.

In March 1970 he was admitted to the Middlesex Hospital for repair of the hernia and excision of the nodules. At operation on 18 March tumour was found attached to the anterior abdominal wall, and the small bowel was invaded and partially obstructed by tumour. The affected bowel was resected and the incisional hernia repaired. Postoperatively he developed a small-bowel fistula and intestinal obstruction, and on 10 April additional small bowel and transverse colon involved by tumour were excised. Unfortunately he again developed a small-bowel fistula, draining up to 2 litres in 24 hours. In spite of intravenous fluids and a restricted oral intake for four weeks the fistula continued to leak copiously, and showed no signs of healing.

On 9 May he was started on 1,800 calories daily of a synthetic low-residue diet (Vivasorb) as the only oral intake, and by the third day drainage from the fistula had obviously diminished. The wound needed dressing less frequently, and he left hospital on 25 June with a very small amount of drainage from the fistula. The diet was stopped at this time and normal feeding recommenced. The fistula continued to heal, finally closing in November 1970.

The diet is composed entirely of amino-acids, vitamins, minerals, simple carbohydrates, and an essential fat. It is almost completely absorbed and therefore faecal elimination is strikingly reduced.[1] Moreover, it has been reported to have a "sterilizing" effect on the bowel, in the sense that some species of bacteria are reduced in number, without growth of resistant strains or proliferation of yeasts.[2] The diet has been fed to healthy volunteers for 22 weeks with no ill effects,[3] and also to phenylketonuric children for 30 months, resulting in an increase in their growth rate.[4] Thus the diet appears to be complete, and seems ideally suited for use in small bowel fistulae, if conventional treatment fails. Its use in this situation has already been reported,[5] but the present patient's response was remarkable because the fistula was due to carcinomatous involvement of the bowel.

I should like to thank Mr. G. N. Lumb and Mr. Adrian Marston for permission to report this case; and also New Chemical Nutrients Limited, who supplied the synthetic low-residue diet (Vivasorb).—I am, etc.,

D. J. GRUNDY

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2 Winitz, M., *et al.*, *American Journal of Clinical Nutrition*, 1970, **23**, 546.
3 Winitz, M., Seedman, D. A., and Graff, J., *American Journal of Clinical Nutrition*, 1970, **23**, 525.
4 McKean, C. M., *Lancet*, 1970, **1**, 148.
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Encouraging Recruits in Medicine

SIR,—I would be grateful if you would allow me to reply to Dr. Susan Mitchley's letter (15 May, p. 403). Her description of the student nurse's lot as a "thankless back-breaking task" does not bear much relationship to what I saw while working as a nursing auxiliary. I would accept her description of the student laboratory technician's job as substantially correct.

She has, I am afraid, missed the point of my letter (1 May, p. 281). Both of these groups have been able, through the exertion of political force, to obtain an income that is commensurate with their present and future contribution to society. Medical students are not in such a fortunate position, and it is surely reasonable to hope that the medical profession as a whole would be willing to exert a fraction of its not inconsiderable political power on our behalf.

To give clinical medical students grants on the same level as other postgraduate students would add perhaps 10% to the cost of our training and would enable us to stand on our own feet instead of on our parents' toes.—I am, etc.,

A. R. W. FORREST

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Adynamic Ileus and Amitriptyline

SIR,—Amitriptyline-induced ileus has been reported previously,[1-3] but there remains a lack of awareness of this danger, as the following history demonstrates, when patients are admitted as emergencies.

A previously healthy 53-year-old woman complained of lower abdominal pain, and was passing two to three loose stools a day. Three days before admission the pain became worse with absolute constipation. There was no history of drug taking. She was obese, and had abdominal distension, absent bowel sounds, and an empty rectum. The blood pressure was 110/80. The important investigations showed W.B.C. 5,000/mm^3, E.S.R. 106 mm/1 hr., blood urea 95 mg/100 ml, electrolytes normal, serum amylase normal. Radiography showed distended coils of large bowel.

Papaveretum 10 mg and atropine 0·6 mg was given intramuscularly, and an intravenous infusion of dextrose saline set up. Anaesthesia was induced with thiopentone 250 mg and suxamethonium 70 mg. A cuffed endotracheal tube was passed and anaesthesia maintained with 50% nitrous oxide in oxygen with d-tubocurarine 30 mg for relaxation and a Barnet ventilator.

At laparotomy a large quantity of serous fluid was found in a hyperaemic peritoneal cavity with gross distension of terminal ileum and complete colon. All organs were normal. A sigmoid colostomy was performed. During handling of the intestines the systolic blood pressure fell to 40 mm Hg. Metaraminol 2 mg failed to improve it, but hydrocortisone 200 mg succeeded in raising the systolic pressure to 75 mm Hg. Reversal of relaxant was by atropine 0·6 mg and neostigmine 2·5 mg and thereafter the systolic blood pressure was 80 mm Hg, but no diastolic pressure could be registered for a further 24 hours.

Subsequently she developed acute renal failure, congestive cardiac failure, jaundice, burst abdomen, and infection of lungs and wound. It was necessary to continue steroids for 27 days postoperatively to maintain an adequate blood pressure and renal output. She returned home after ten weeks and is very well six months after admission. It was suspected, but only diligent questioning revealed, that she had been taking amitriptyline intermittently for some weeks before admission.

The presentation closely resembles that described by Caves and Crockard[4] as pseudo-obstruction of the large bowel, but in our patient there was no other lesion. The only possible aetiological factor was ingestion of amitriptyline. That she took it irregularly may explain the slow onset of ileus.

I thank Mr. D. V. Morse and Dr. R. G. Paley for their help.

—I am, etc.,

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1 Burkitt, E. A., Sutcliffe, C. K., *British Medical Journal*, 1961, **2**, 1648.
2 Gander, D. R., Devlin, H. B., *British Medical Journal*, 1963, **1**, 1160.
3 Milner, G., Buckler, E. G., *Medical Journal of Australia*, 1964, **1**, 921.
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Size of Medical Records

SIR,—I was alarmed to read of the General Medical Services Committee's recommendation that medical records of the future should be able to contain unfolded A4 size paper.[1] For the vast majority of the population the present-sized medical record envelope is quite big enough to record a medical history. For the few with a longer history, a little ingenuity and an occasional summary is usually sufficient.