Elective Surgical Treatment of Duodenal Ulcer

SIR,—In the report on their controlled trial of truncal vagotomy and drainage for duodenal ulcer Mr. F. Kennedy and other members of Professor A. W. Kay's department at Glasgow (14 April, p. 71) record results which will be regarded by many surgeons as astonishing for their excellence. Thus no less than 86% of the patients after vagotomy and gastroenterostomy were classified by them as being in Visick categories I (excellent) and II (very good), a figure that rose to 92% when the outcome of reoperations for recurrent ulceration or bilious vomiting was included, leaving only 7% in category III (indifferent result) and 1% in category IV (failure). By comparison, in the Leeds/York controlled trial[1] of three different operations for duodenal ulcer we considered that only 70% of our patients after vagotomy and gastroenterostomy qualified for Visick categories I and II, no less than 19% were placed in category III, and 11% had to be relegated to category IV; moreover, these proportions were not substantially altered by incorporating the results of reoperations.

It is a matter for conjecture as to why there should be this difference in the findings of these two inquiries, and several factors may be considered. The Glasgow trial involved a mean follow-up period of only four years, and 20% of the patients were lost to follow-up, while in the Leeds/York trial the follow-up was continued for five to eight years and all but 4% of the patients were traced. A difference in the quality of surgical skill in the two centres seems unlikely. More plausible is that the types of patients included in the two trials may have been somewhat different, or, most probable of all, that the stringency with which the Visick criteria were applied may have varied. But whatever the explanation for the divergence of results, there is certainly no reason to suppose that the accomplishments of the average surgeon throughout the country with this operation are more reliably reflected by the findings of the Glasgow trial than by those of the Leeds/York one.

On the basis of their inquiry the authors feel that truncal vagotomy with drainage represents virtually the acme of surgical achievement in the elective treatment of duodenal ulcer and that little scope remains for further improvement. Our results in the Leeds/York trial, and in other studies,[2] on the contrary, indicate that after most operations for duodenal ulcer there is a hard core of between 25 and 30% of indifferent or frankly unsatisfactory results, which would seem to leave a fair amount of room for amelioration. Whether in fact proximal gastric vagotomy (syn: highly selective or parietal cell vagotomy) without drainage, which is currently the standard elective operation for duodenal ulcer in this department, will produce significantly better results remains to be established, for I entirely agree with Mr. Kennedy and his colleagues that the value of this new operation is still sub judice and will continue so until it has been more thoroughly assessed by longer follow-up studies, preferably as part of controlled randomized trials. I fully accept that we in Leeds are open to severe criticism for not having seized the golden opportunity presented by our pioneer interest in this new operation to institute such a trial of it long ago. It is also perfectly true that proximal gastric vagotomy is technically a considerably more demanding operation than truncal vagotomy and drainage, but, with attention to detail and a certain amount of practice, it soon becomes quite feasible, if a little time-consuming, in all but the grossly obese, even in the hands of a surgeon such as myself, whose time in the operating room is largely directed to other fields than gastric surgery. As for its suitability for men in training, my impression is that, whatever operation is being regularly performed by consultants, is soon done even better by their senior registrars.

Certainly, I should be failing in my duty if I did not reaffirm in the strongest terms that our results with proximal gastric vagotomy without drainage in Leeds in over 250 patients with duodenal ulcer in the past four years have been most encouraging to date, with no operative deaths, no significant gastric retention, virtually no diarrhoea, only two suspected and no proved recurrent ulcers, and high Visick gradings. I think that it would indeed be a great pity if this new technique, which is based on such an idealistic conception—after all, it could be regarded as the realization of Lester Dragstedt's original dream of a pure neurectomy for peptic ulcer without surgical intervention in the stomach itself—and which shows so much initial clinical promise, should be extinguished in its first flickering phase by a blast of scepticism from such a distinguished and respected figure of British gastroenterology as Andrew Kay.—I am, etc.,

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1 Goligher, J. C., *et al., British Medical Journal*, 1968, 2, 781.
2 Goligher, J. C., *et al., British Medical Journal*, 1972, 1, 7.

Stress and Myocardial Infarction

SIR,—With reference to the study by Mr. M. Shelton and Dr. J. Dominian of psychological stress in the wives of patients with myocardial infarction (14 April, p. 101), showing an increased incidence of depression and guilt in the wives, may I suggest that, in some cases, these were present before the attack and might have been a major cause of it?

Is it possible that a higher proportion than average of the men who have infarcts, the younger men in particular, have wives who are prone to depression and anxiety neurosis? Much is written of stress factors at work, even travelling to work, but to many men the greatest stress in their lives must be at home where they are continually striving to "make things better" in the misguided hope that it will improve their wives' attitude towards life. The more concerned the husband, the more will be his frustration and sense of failure. This is not to say that every infarct in a younger man with an anxiety-depressive wife is caused by the wife. It might be that the personality and life style that predispose a man to myocardial infarction also predispose his wife to anxiety neurosis and depression.

Possibly the facts that men are dying relatively younger than women, particularly of coronary artery disease, and that women are becoming more vocally discontent are related. Certainly it would be of interest, in a large number of cases of myocardial infarction in men, to study the wife's mental state before the attack. Perhaps future attacks might be prevented in some cases not by trinitrates for the husband, but rather by tricyclics for the wife.—I am, etc.,

B. N. J. DAILY

Burnham, Bucks

David Livingstone

SIR,—The courtesy and respect shown by David Livingstone to the African traditional healers, referred to in Professor George Shepperson's article (28 April, p. 232), extended to a willingness to submit himself to their ministrations. "When attacked by the fever myself, and wishing to ascertain what their practices were, I could safely intrust myself in their hands on account of their well-known friendly feelings."[1] Of one such episode he writes, "I fondly hoped that they had a more potent remedy than our own medicines afford; but after being stewed in their vapour baths, smoked like a red herring over green twigs, and charmed 'secundem artem,' I concluded that I could cure the fever more quickly than they can."[2] He considered the treatment helpful, however, with the addition of "a mild aperient in combination with quinine."

Livingstone's tact gave him the opportunity of proffering acceptable advice. "Any explanation in private was thankfully received by them, and wrong treatment changed into something more reasonable with cordial good will, if no one but the doctor and myself were present at the conversation."[3] Whether, in that era, Livingstone's methods were a great advance upon those of his African colleague may be open to doubt, but his approach in developing rather than discarding the skills of traditional practitioners foreshadows more recent programmes especially in the fields of midwifery and psychiatry.[4]—I am, etc.,

FRANK ASHWORTH

Liverpool

1 Livingstone, D., *Missionary Travels and Researches in South Africa*, p. 164. London, Ward, Lock, 1899.
2 ibid, p. 170.
3 ibid, p. 114.
4 *Medical Care in Developing Countries*, ed. M. King, pp. 3:10, 19:2, 20:6, Nairobi, Oxford University Press, 1966.

Livingstone's Example

SIR,—In your leading article (28 April, p. 196) it is stated that some chroniclers have wondered why Livingstone on occasions spoke of trade "as though it were part and parcel of the Christian religion."

We should learn that trading and Christianity are indeed synonymous. They are the pursuit of truth. Human beings claim rights, which is simply to say that they want conditions in which they can care for their minds and their bodies. If people expect rights they must also supply them for their neighbour, otherwise their neighbour has no source of his rights. Then we claim the lowest price, which is simply to say that we expect the most considerate sale. Individuals cannot

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contribute aptitudes which they do not possess, hence there is exchange.

Christ lived and He showed us how to turn our longings to success: we must think of others not of ourselves. It has never been refuted that He rose from the dead, and His spirit is with us if we want to accept it.—I am, etc.,

MARY D. SMITH

Glasgow

Infantile Hodgkin's Disease: Remission after Measles

SIR,—The remission of Hodgkin's disease in children after measles is a rare event.[1 2] I should like to report a cure seen at the Paediatric Clinic (Professor S. Bessa), University Hospital, Coimbra.

A 23-month-old caucasian male was seen for the first time in April 1970 with a large mass in the neck due to hypertrophy of the left cervical lymph nodes (see fig.). The mass had first been noticed in November 1969. The child had no fever or pruritus, the chest *x*-ray film was normal, the E.S.R. was 9 mm in the first hour, and the haemogram was normal with no eosinophilia. An intradermal skin test to *Candida albicans* antigen 1 : 100 (Bencard) was negative. A diagnosis of predominantly lymphocytic Hodgkin's disease was made on the histopathological findings of lymph node biopsy (Professor R. Trincao).

Before radiotherapy could be started the child developed measles. Much to our surprise the large cervical mass vanished without further therapy. The chest *x*-ray picture remained normal but the haemogram showed pronounced leucopenia (3,400/mm^3). It was decided not to start radiotherapy, and the child remained symptom free for six months. New intradermal tests for Candida were done 2-5 months after the measles episode, and this time they were positive. The immunoglobulins remained normal.

In November 1970 the child's mother noticed he had erythematonstash soon after he had drunk some wine. It covered the face and the area of the neck corresponding to the site of the lymph node biopsy, where enlarged lymph nodes were again palpable (fig.). The haemogram, chest *x*-ray film examination, and Candida skin test were repeated. There was pronounced oesinophilia (11%), the chest *x*-ray film remained normal, and the response to Candida was again negative. Another biopsy showed Hodgkin's disease of mixed cellularity. In view of this relapse irradiation with cobalt-60 was started, and after a total dose of 3,000 rad at the rate of 300 rad every other day (Portuguese Institute of Ocology, Coimbra) the child re-entered a remission period which has lasted for 18 months.—I am, etc.,

H. CARMONA MOTA

Department of Paediatrics,
University of Coimbra,
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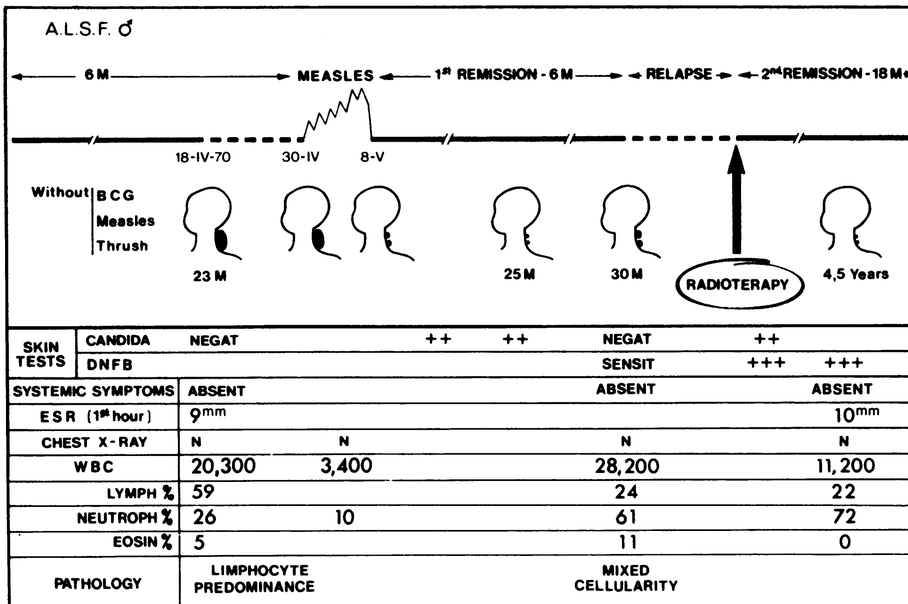
1 Hernandez, S. A., *Archives Cubanos de Cancerologia*, 1949, 8, 26.
2 Zygiert, Z., *Lancet*, 1971, 1, 593.



Research Investigations in Adults

SIR,—With reference to the tape-recorded discussion on this subject (28 April, p. 220) there must be few who would dispute the necessity and value of ethical committees in all hospitals, especially where there is a research interest, but their work must extend further than the walls of a committee room where the members deliberate on the moral and scientific aspects of any project.

As a ward sister in the clinical research centre at Northwick Park I was very aware of conflict experienced by those concerned with the day-to-day care of patients involved in research. The question of informed consent is indeed difficult. I always felt it my responsibility to be sure that any patient understood fully what was happening to him, whether or not it was research, and that he knew he had the right to refuse without any repercussions. Even though most consultants are good at explanations, there are still many patients who are afraid of them and feel happier asking questions of a nurse or junior doctor whom they see every day. In fact this pays dividends, as once the patient feels involved in his own investigation or treatment he is more co-operative and everything runs more smoothly. On several occasions I was asked, "Is this the guinea-pig hospital?" and it is only by being absolutely honest with patients and their relatives that the community's trust in its hospital will be maintained, especially when routine procedures become more complex and less comprehensible.

This draws to light the dual position in which the nurse (and also to a large extent the junior hospital doctor) in a research team finds herself. On the one hand she feels it her duty to protect the patient against the enthusiasms of investigators, and on the other she is part of a team striving to achieve a particular goal, and this can sometimes present difficulties. If she is too much on the side of the patient she may be pressurized by the medical staff and if she is inclined the other way she (quite rightly) has to justify the investigations to the junior nurses.

A third difficulty, and possibly the most disturbing, is that it can be very difficult to distinguish between clinical research and beneficial investigation. I trained as a nurse, not a scientist; my knowledge of the sciences and technology is basic, and therefore explanations and understanding of some projects can be difficult. (Indeed, can all doctors understand one another's work?) In this situation an investigator could "pull the wool over the eyes" of the ward sister or she might, wrongly, think this is happening. If her trust and co-operation are to be maintained it is vital that there is someone to whom she can turn for unbiased advice.

Lastly, never let it be said that any procedure is trivial; even a 24-hour time urine collection may cause anxiety if it means that a mother has to spend an extra night away from her young children, and I have known the fear of venepuncture the next morning disturb a patient's sleep.

As Dr. M. D. Eilenberg pointed out in the discussion, the best way to ensure ethical control is to establish an "ethical climate." This will not be achieved if the committee is a remote body sitting in an ivory tower. It must make itself aware of the effect of its decisions and be accessible to the opinions of everyone—including the most junior of students and the patients themselves—if there is to be the mutual trust vital for the survival of any institution.—I am, etc.,

JANET E. ANDREWS

Ilford, Essex

Treatment of S.L.E Nephritis

SIR,—The article on treatment of systemic erythematosus (S.L.E.) nephritis with chlorambucil by Dr. M. L. Snaith and others (28 April, p. 197) provokes comment. In the first place it seems that when faced with steroid intolerance, rather than try alternate-day therapy, high-protein diet, combination with diuretics, and other immunosuppressives such as azathioprine to achieve steroid-sparing effect, they have chosen to change to chlorambucil. This is a nitrogen mustard derivative like cyclophosphamide, which they have shown to produce amenorrhoea, and it is surprising that they claim that it produces less marrow suppression. Such has not been my experience in treating cases of cold agglutinin haemolytic anaemia with this drug.

I find the suggestion that chlorambucil could be superior to cyclophosphamide equally surprising; no theoretical basis for this is given. While not denying that cyclophosphamide therapy has its complications,

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