

of an acute episode of abdominal pain and presented the findings at the meeting of the British Paediatric Association in 1975. Briefly, we found that the 235 admissions with acute abdominal pain accounted for 9.4% of non-waiting-list admissions in that 12-month period. Thirty-one admissions were for chronic or recurrent pain and 204 for acute pain. A breakdown of diagnoses followed the same general pattern as found by Mr Jones and was as follows:

Unexplained	36%
Appendicitis	28%
Upper respiratory infection (including 7 cases of influenza B)	11%
Constipation with soiling or urinary retention	3%
Gastroenteritis	3%
Urinary infection	3%
Mesenteric adenitis	3%
Major psychological problems	3%
Pneumonia on chest x-ray	2%
Miscellaneous (including 5 admissions with duodenal ulcer pain)	8%

Laparotomy was performed in 78 instances and in only five was no abnormality found. Seven of eight children aged between 3 and 6 years with appendicitis had peritonitis or abscess formation at the time of laparotomy and only 37.5% of these were in hospital within 48 h from the onset of pain compared with 83% of children aged 9-12 years. Overall, for children with appendicitis there was a significant difference in the delay before admission to hospital between the uncomplicated and the complicated cases. Reasons for delay were not always recorded, but in five of the 14 instances in which delay extended into the third day the family doctor had not been called. In another five instances the family doctor had visited before the third day but thought that the pain was non-surgical in origin and did not arrange admission.

Thus 10 years after Jackson's paper we found continuing evidence of the same delays. Further improvement in the morbidity and mortality of acute appendicitis will come only when parents are educated to call the family doctor if any abdominal pain in a child lasts eight hours or more and family doctors refer the young patient with abdominal pain to hospital earlier than at present.

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¹ Jackson, R H, *British Medical Journal*, 1963, 2, 277.

Closure of dirty and untidy wounds

SIR,—It is always reassuring to see fundamental principles of surgery being restated as in your leading article on this subject (11 September, p 600). I would suggest, however, that those of us who instruct undergraduates and junior doctors in the management of dirty and untidy wounds in accident and emergency departments are in a very strong position to inculcate these basic principles at the beginning of their training. There are many so-called minor wounds (such as animal or human tooth wounds and flap avulsion wounds of the shin in middle-aged or elderly ladies) which are best treated by adequate primary excision followed by delayed primary closure, as indicated in your leading article. This can often be carried out as an outpatient procedure.

Good habits instilled thus early in training are likely to be carried over into the more major injuries which a doctor will be meeting later in his professional life.

Finally, application of these principles to such minor wounds must surely result in a greater total saving of disability in the community than results from the proper treatment of the much less common, but more serious, wounds which require inpatient treatment.

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Medical newspeak

SIR,—I wonder if many of your readers are subjected to this latest craze. I know psychologists often have a varied and difficult professional task. Nevertheless, is the jargon in this copy of part of a letter from a psychologist to her psychiatrist about a patient of mine really helpful?

(1) Ventilation of sexual material with the view to a reduction in her tremendous sense of guilt and worthlessness.

(2) Deflection of her present involvements into more satisfactory and acceptable people of both sexes.

(3) Lessening of her social phobias by planned outings, etc.

(4) Exploration of the family situation and assistance in separating herself from them, aiming towards moving out of home eventually.

(5) Exploration of the possibilities for improvement in her work situation, through help toward accepting more responsibility leading towards promotion or a change of job.

I cannot print my partner's interpretation of the first undertaking. Though somewhat cryptic, could we not have had:

(1) Talk sex to gain confidence.

(2) Select friends.

(3) Go out.

(4) Leave home. (In fact this would have solved the lot.)

(5) Change job.

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Teaching of anatomy

SIR,—As your leading article (11 September, p 603) rightly suggests, the teaching of anatomy to the undergraduate and to the surgical trainee are not separate issues. Poor pay, inferior status, and the continuing rigid boundaries between preclinical and clinical departments have led to a dearth of medically qualified teachers in anatomy. This can result only in anatomy teaching which is research and not clinically relevant, confirming the opinions of those misguided medical educators who see no reason for any anatomy teaching at all.

The solution is in the form of the anatomy demonstratorship for surgical trainees. This fulfils two needs. The first is for clinically relevant topographical anatomy teaching which is economical in its consumption of curriculum time. In Bristol the demonstrators prepare dissections before teaching and as a result students spend only 160 hours in the dissecting room in their two preclinical years. The second need is for a basic anatomical grounding for the surgical trainee. In no other situation can the aspiring surgeon enjoy open access to dissection material and this unique opportunity to learn anatomy. I would urge that at least six months in an anatomy demonstratorship be included in the long-term surgical training programmes which are now evolving

in many centres, for the benefit of the future of surgery and the quality of undergraduate anatomy teaching.

Continuing education in anatomy for the surgeon goes hand in hand with increasing operative experience; this could be supplemented by the use of audiovisual aids, such as film loops on the anatomy of a specific area, or even the provision of a prepared cadaver as in some residency programmes in the United States. After all, some of our most eminent surgical forefathers spent an hour in the dissecting room before tackling a particularly challenging case.

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Management of appendicitis

SIR,—The complications of appendectomy continue at an unnecessarily high rate, possibly because the facts available in the literature have not been combined in a single clear statement.

I recently carried out a retrospective survey of wound infection in 140 consecutive appendicectomies in the King's College Hospital Group with particular reference to the antibiotic-using habits of the surgeons (all senior registrars or registrars with FRCS) supervising or performing the operation and the state of the appendix at operation. If we exclude those who did less than five operations or who were totally consistent in their use or non-use of antibiotics there remain 94 operations performed by discriminating surgeons. When the appendix was described as infected or inflamed by both surgeon and histologist they used antibiotics 15 times, with two subsequent wound infections, and refrained 42 times, with 11 infections. This is the same advantage of 1:2 found in the prospective study of Gilmore and Martin¹ and so confirms the notion that there is no way of judging when to use an antibiotic in these circumstances. When the word "pus" or "gangrene" appeared they used antibiotics four times and refrained 13 times, with a total of eight wound infections. When the word "perforation" was used 10 out of 11 gave antibiotics, with nine infections, while the eleventh patient, without an antibiotic, suffered both a wound infection and a pelvic abscess.

I believe there is now sufficient information on which to make rational choices in managing this disorder, based on the appearances at operation:

(1) If the appendix is normal or inflamed a topical antibiotic or povidone-iodine will decrease the chance of wound infection by half or more (roughly, from 20% to 10%).¹ Systemic antibiotic treatment will very probably eliminate the chance of intraperitoneal complications at all stages of the disease but will have to be given to 40 patients in this group unnecessarily for each successful prevention.²

(2) If the appendix is gangrenous the chance of wound infection increases to 50% or more, the most effective local agent is probably povidone-iodine, and the chance of intraperitoneal complications rises to about 12%, making systemic antibiotic treatment more worth while.²

(3) If the appendix is perforated the chance of wound infection rises to 80% and of intraperitoneal complications to 40%. Clearly systemic antibiotics are indicated, with a wider spectrum than metronidazole alone, but neither systemic nor topical antibiotic treatment improves the wound infection rate,^{1,2} and rubber drains are valueless.²

May I suggest that we cease to suture the