an already extensive operation. The morbidity and mortality of this procedure would certainly outweigh any possible advantage gained by adequate clearance. It seems logical, however, to pay more attention to the possibility of transpyloric extension of carcinoma by doing an adequate duodenal resection determined by frozen section biopsy specimen at the point of transection. Guidance is given by Castleman,⁷ who found that the length of the spread into the duodenum in his patients ranged from 4 mm to 23 mm. Thus a resection of at least 3 cm of duodenum is suggested on pathological grounds; and this should easily be achieved in all cases without increasing the surgical risk. Perhaps nearly 50 years after this evidence was presented it bears repetition in an attempt to improve the chances of survival of our patients with gastric cancer.

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Dealing with the Disadvantaged

Bereavement

PADDY YORKSTONE

The break-up of the extended family, a conspiracy of silence surrounding death, and a lack of mourning ritual leave many bereaved unsupported. At this vulnerable time they may turn increasingly to doctors and health workers for help.

After a death families, friends, and neighbours often offer immediate help to comfort the bereaved and deal with the practicalities of funeral arrangements. The critical period follows when this help ceases and the initial feelings of numbness or shock give way to intense grief. Although for many grieving will take its normal painful course, some (perhaps a quarter to a third) will be at risk during this time if unsupported.

Risk factors

- (1) Sudden, unexpected, and untimely death—for example, fatal accident or suicide in a child or young adult.
- (2) Demands of dependents: children and others.
- (3) Lack of a close relationship or a warm, supportive family. Presence of a family who block attempts to grieve—for example, after stillbirth or neonatal death.
- (4) Financial hardship and housing difficulties.
- (5) Non-employment: at home all day—particularly mothers of young children and the elderly.
- (6) Earlier difficulties in accepting impending death; clinging and pining or excessive anger and self reproach.
- (7) Multiple losses.

- (8) Vulnerable personality—for example, history of mental illness or inadequacy.

Problems facing the bereaved

- (1) Practical difficulties in taking over unaccustomed functions of the deceased: widow, business affairs; widowers, domestic responsibilities and child caring.
- (2) Physical symptoms, which are normal physiological accompaniments of grief, may be self-perpetuated by the bereaved's fear for his own future health—for example, tachycardia, anorexia, insomnia, indigestion, and headache.
- (3) Loneliness and isolation often increased by the community's embarrassment and inability to mention the death or the deceased.
- (4) Dealing with the grief of other members of a family in addition to his or her own: particularly hard for the surviving parent of young children.
- (5) The frightening intensity of grief, sometimes accompanied by feelings of panic or suicidal thoughts (no diffidence should be felt in asking a direct question about suicide).
- (6) Fears of "breakdown" often spoken of after experiencing vivid illusions: "sights" or "sounds" of the dead person, or forgetfulness.
- (7) Lack of an outlet for the expression of guilt and anger.

Needs of the bereaved

- (1) To be allowed to talk about the experience: the illness, death, funeral, and memories.
- (2) To have expressions of grief accepted.

(3) To know that some guilt and anger is usual and to be able to talk of this although it may be directed towards the care givers.

(4) Sometimes the bereaved need protection from well meaning "escape" routes urged upon them too soon or from attempts to stop them grieving—for example, change of house or job; prolonged visits to friends or family to delay returning to the empty house.

(5) Direction towards sources of practical help: Citizens Advice Bureau; Department of Health and Social Security booklet *What to do after a Death*.

(6) The first anniversary is a crucial event; a contact around this period is greatly appreciated and it is a good time to assess the progress of the bereaved person.

(7) The need of children to grieve is not always recognised and shared in families and some will require special help.

(8) Occasionally the bereaved need "permission" to stop grieving and require help to adapt to new roles.

(9) A lifeline: a phone number or other means of contact. Many bereaved are vulnerable and insecure and often unable to make demands or ask for help. An appointment not kept or promise of contact not fulfilled can be devastating.

There are many national and local organisations available to help including Cruse (for widows, widowers, and their families); Compassionate Friends (for bereaved parents); Stillbirth Association; Foundation for the Study of Infant Deaths; and Gingerbread (single parent families).

MATERIA NON MEDICA

Midwife to the hairy drinkers

An invitation to sail in a Nicholson 45 from Falmouth to the Solent for Cowes Week was too much for a 14-year-old to resist. But the summer is a busy time for lepidopterists. The reproductive cycle is in full swing, so a locum midwife had to be found. "Don't worry, Mother. They will all pupate in a few days," said the departing figure.

The larvae were numerous and had varying diets, but they looked benign enough. Only the hairy drinkers had to be avoided, for handling them produced an irritating rash on the fingers. However, it soon became apparent that elephant hawks have an astonishing capacity for converting willowherb into body mass. An equally astonishing output of excreta meant that not only was a fresh supply of willowherb required daily, but their container must needs be cleaned out too. "They are very prone to virus infections if not cared for properly," sounded a warning echo in my ear. In two weeks the caterpillars grew from being tiny creatures less than 1 cm in length to monsters 6 cm long, as thick as a finger, with baleful protective eye markings at their rear end. Mucking-out took on Augean proportions. As they grew they became increasingly aggressive, while their nimble turn of foot belied their gross appearance. Some would rear up and turn on one as if to bite, the attack usually coming from an unexpected quarter, as one tended to watch the "eye" at the wrong end. Others attempted to escape under the watchful gaze of Pussy, who knows a tasty morsel when he sees one.

On the day of the sailor's return the elephant hawks pupated. "I told you they wouldn't be any trouble." Among the fresh green willowherb in the spotless container he did not notice that two were missing. Was Pussy looking more smug than usual?—BARBARA PHILLIPS (clinical assistant, Bath).

Quinag

Perhaps it is fair to join the musical purist who dislikes pictorial imagery in relation to great compositions with the biologist who correctly objects to anthropomorphic imaging of animals. Some innocent enjoyment can be missed by a too serious approach.

Of all Scottish mountains Quinag may not be the most beautiful, but its situation is surely unequalled. The approach to the least high part of the summit—Bealach a Chornaidh—results in joining the Y-shaped massif immediately south of the two limbs of the Y. The going is wet but easy. Grand vistas open behind, and, tucked closely under the southern top, Spidean Coinnich, is a small red sand shored loch whose surface is textured by wind and coloured by reflections from the ribbed cliffs above. Themes from Sibelius provide the mood for the approach.

For two middle-aged walkers, softened by city practice in law and in medicine, breathlessness on the steeper scramble to the ridge banishes talk but encourages "mind music," and the sudden revelation of the western panorama when the ridge is reached recalls Sibelius's most triumphant themes. Far below to the west is a rough low-lying land of rock and water, dappled sunlit areas, and a ragged coast with white broken lines of breakers so distant as to seem still. The sea: green, blue, and grey. Clouds change in form with every minor front from the Atlantic for change is rapid in these parts. On the far

horizon, sometimes just a shadow, lie the outer Hebrides. Inland rise strange mountain forms. The mystic sounds from Beethoven's Quartet Number 132 express more than words.

Returning over Spidean Coinnich the southward view over the unique Assynt hills is unveiled: Canisp and Suilven, Cul Mor and Stac Pollaidh, and an infinity beyond. Now the sun is in the west, and the peroration of Sibelius's second symphony says it all.

From within the Quinag massif the Spidean is Sphinx-like. Much more a huge petrified monster than the water bucket which gives Quinag its name. On a previous visit here the slopes bristled with scale-like rocks angled threateningly through the snow with snow "devils" whirling among them in the blast, but in the blue and gold of the afternoon sunlight all is peace with a sense of immensity of time and space. "The Song of the Earth": "Everywhere and forever blue shines the Horizon . . . ever . . . ever . . ."—W J M HOOD (general practitioner, North Humberside).

A surgeon's sporting dilemma

I have often wondered how doctors, surgeons in particular, react when they come up against one of their past patients in a one-to-one sporting contest. As for myself, I face the occasion with some trepidation because a victory in my favour makes me wonder if, after all, I did do a good enough job on my opponent—professionally I mean. In this case it was soon obvious.

Just before a squash match my opponent said to me, "Don't you remember me? You did two ops on me, the second was only a couple of months ago. I seem to have recovered now." My guilty conscience made me feel that his second remark had a touch of surprise, suggesting some kind of a surgical misadventure in our past professional encounters. It was the way he said it. Such comments flung at a surgeon just before a match do not do a great deal for his squash ability, especially when it is as limited as mine. During the match various thoughts went through my mind, none of them having anything to do with squash. "Was it an incisional hernia the second time round? Or was it a recurrence of an inguinal hernia?" I was convinced that his second operation was necessitated by some mishap following the first. Most of them are. I was so immersed in my opponent's past surgical condition that in no time I found myself two games to love down. With great difficulty I hauled myself up to two games all when the surgeon in me took over once again. "Maybe it was simple removal of a toe nail followed by recurrence needing radical removal second time round." Quick as a flash I realised that he was moving far too well for one of my "postoperative toe nails," albeit two months later. I was well beaten. Time for a shower. Decided to do an unsuspecting postoperative follow-up at the time. I looked him up and down—no scar to be seen at all and normal toe nails. My curiosity almost got the better of me when he quipped, "Yes, have not had any trouble since you did my circumcision and last week I got the 'all clear' for my vasectomy."

Driving home, feeling dejected at letting the side down, I gained consolation from the thought, "At least my first operation must have been pretty successful for him to return for the second one."—PRADIP K DATTA (consultant surgeon, Wick, Caithness).