

prevalence figures, from well populations and hospital clinics, which in turn are the result of self-selection, referral patterns, and the age composition of the screened population. The data emphasise that, with a trend towards less selection of women for screening, the predictive power of a positive diaphanoscopy test would be lower and that for a negative test higher than in their series.

One case appears to be missing from their results but it does not materially influence the outcome.

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<sup>1</sup> Vecchio TJ. *N Engl J Med* 1966;274:1171-3.

<sup>2</sup> Strax P. *Surg Clin N Am* 1978;58:667-79.

<sup>3</sup> Kapdi CC, Wolfe JN. *JAMA* 1976;236:1124-7.

<sup>4</sup> Devitt JE. *Lancet* 1976;i:793-5.

### Mortality from coronary heart disease in the British army compared with the civil population

SIR,—I was most interested in the paper (8 August, p 405) "Mortality from coronary heart disease in the British Army compared with the civil population," particularly the findings of a high mortality in the age group 20-39 years.

In a paper I published,<sup>1</sup> while I was principal medical officer at the Ministry of Pensions, on coronary occlusion in young adults I reviewed 100 cases in the services under the age of 35, and I also found a very high mortality in these young cases—80 deaths out of 100—and in most of these fatal cases death took place suddenly. It was noteworthy that practically all the sudden deaths were in apparently fit and healthy men who had previously carried out their military duties without any signs of cardiac distress, the disease being unsuspected during life and diagnosed only at necropsy.

The degenerative changes found in the coronary vessels were similar to those found in older age groups, the arteries being thickened, tortuous, and calcified—a thrombus was found in only 22 of the 80 fatal cases. Despite the youth of the men the pathological findings indicated that the process had been present for many years and that in these young cases genetic influences appear to be more important than habits of life and work.

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<sup>1</sup> Newman M. *Lancet* 1951;i:1045-8.

SIR,—Major Peter Lynch and Mr B J Oelman (8 August, p 405) discuss the observed differences in mortality from coronary heart disease between officers and soldiers. These differences are then related to the respective life styles.

Although figures are not quoted it is inferred that officers smoke much less than soldiers. There is no reference to alcohol intake, which might be a factor. Dietary differences are possibly relevant but it is true that 53% soldiers who are married eat food similar to any other British household? I contend that, generally, officers may still be more sophisticated in dietary habits and probably consume

less convenience foods, carbohydrates, and fats. Army catering does indeed offer the living-in soldier a large choice of menus, generally more so than the living-in officer. Might this not be an adverse factor? Obesity is actively discouraged but it is still a problem in the Army—more so in soldiers than in officers in my current general practice experience.

Moreover, the physical service experience and standards of fitness of officers and soldiers may not in fact be similar. I suggest that, at regimental level, the under-40 officers are, in general, fitter than many of their soldiers. Finally, are there other differences between officers and soldiers—for example, between those living in married quarters and those living in single accommodation in barracks, etc?

I make these few suggestions to stimulate further studies to complement this good and useful paper by Major Lynch and Mr Oelman. We need to know much more about the differences in life styles as well as the socio-economic backgrounds of officers and soldiers. As these factors are constantly changing, ongoing prospective studies would seem to be really well worth while.

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### Why treat cirrhosis?

SIR,—Although it is often right to question the importance and cost effectiveness of our treatment, your leading article "Why treat cirrhosis?" (1 August, p 338) contains a number of misleading generalisations and half truths. Many of the statements are based on a 20-year study which was completed in 1976<sup>1</sup> and the most recent advances could not have had any impact on survival by that time. In the management of variceal haemorrhage, you do not mention the vital importance of endoscopy to determine the site of bleeding; few surgeons would now recommend a laparotomy because they were not sure of the source of bleeding. Endoscopic sclerotherapy after prompt and effective resuscitation can stop bleeding in over 90% of cases<sup>2</sup> and survival following long-term sclerotherapy is looking promising, with two-thirds surviving over one year after the initial bleed<sup>3</sup> and half over two years (H D Sinnett *et al*, unpublished observations).

While it is true that abstinence from alcohol significantly improves the prognosis of alcoholic cirrhosis, there is no mention of the effects of treatment in autoimmune chronic active hepatitis, Wilson's disease, or primary biliary cirrhosis; 66% of patients with primary biliary cirrhosis survive five years after portal decompression for haemorrhage.<sup>4</sup> Of course, much of our treatment is palliative and there are times when it is right not to employ heroic methods, but this applies equally to many other diseases, from cancer of the stomach and bronchus to coronary thrombosis.

To advocate sedation as part of the treatment of bleeding varices is inconsistent with your earlier statement that liver failure can be induced by overenthusiastic use of drugs. A more positive approach to the high mortality following massive blood loss would be to arrest the haemorrhage and treat the varices early. Awareness of the increasing frequency of chronic liver disease and its likely complications may do much to improve the treatment

and prognosis. The nihilistic attitude taken in your editorial will deny many people many years of worthwhile life.

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<sup>1</sup> Saunders JB, Walters JRF, Davies P, Paton A. *Br Med J* 1981;282:263-6.

<sup>2</sup> Johnston GW, Rodgers HW. *Br J Surg* 1981;60:797.

<sup>3</sup> Clark AW, Westaby D, Silk DBA, *et al*. *Lancet* 1980;ii:552-4.

<sup>4</sup> Spinski R, Smith-Laing G, Epstein O, Sherlock S. *Gut* 1981;22:345-9.

\* \* \* The 20-year study of cirrhosis followed up patients until 31 December 1978, and the only "advance" that could not be assessed was endoscopic sclerotherapy. While this may be effective in the short term, there is as yet no consensus about its role in the long term; and it was the lack of any change in long-term outlook from costly treatments that we sought to emphasise. We accept that treatment is available for chronic active hepatitis, Wilson's disease, and primary biliary cirrhosis; but these constitute less than 10% of all cases of cirrhosis. Surely it is reasonable to concentrate resources on preventing alcoholic cirrhosis, which now accounts for 70% of patients, and on seeking the cause of cryptogenic cirrhosis, which accounts for the rest.—Ed, *BMJ*.

### Career structure: an impediment in academic medicine

SIR,—Professor H A F Dudley's comments (30 May, p 1771) on the uncertain future of academic surgery raise issues that have equal relevance to other specialties.

He is less than optimistic that the "movers and shakers of the world" will triumph over "vibrating mediocrity." I venture to suggest that there are many United Kingdom graduates able and willing to take up this challenge, were it not that their future might thereby be jeopardised; and that the great strength of academic clinical medicine in North America is in no small part the result of the disparate career structure on the two sides of the North Atlantic.

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### Management of scientific services and the changing face of the laboratory

SIR,—Miss Mary Warner (1 August, p 380) felt it necessary to explain the term medical laboratory scientist to "your predominantly clinical audience," as she put it. Unfortunately her personal interpretation is highly misleading. Semantic discussion is not always fruitful but the interpretation of the Institute of Medical Laboratory Sciences—with 17 000 medical laboratory scientists in membership—may be considered relevant by your readers.

There are two main groups of staff associated with medical laboratories: those medically qualified and those—medical laboratory scientists—holding a variety of scientific qualifications. Miss Warner's attempt to separate groups of medical laboratory scientists