habitual lateness will hinder their progress up the greasy pole and be an absolute bar to success in private practice should they have any aspirations in that direction. If trainee surgeons could also be taught that preparing a patient for their knife takes longer than the five minutes they generally allow for changing and scrubbing up knife to skin at 8 30 am would become more of a reality than the myth it now is. But then Mr Datta would have no time to write his delightful articles.

W AVELING

Middlesex Hospital,
London W1N 8AA

SIR,—"We never send for the patient until we see the whites of the surgeon's eyes," the theatre staff have forcibly made clear to me at one of our local hospitals.

Mr Pradip K Datta rightly laments the lack of punctuality with which operations begin and finds his anaesthetic colleagues mainly to blame. The time has come for the profession to reach a consensus on the meaning of the "starting time" of a theatre case and to encourage its realistic use by all concerned.

A difficult aspect of our work as surgeons and anaesthetists is the scheduling of that work in the best interests of all those involved in the safe conduct of an operation: the patient, occasionally parents, ward staff, porters, anaesthetic and theatre nurses, and ourselves. There is, however, no agreement on the meaning of the starting times around which all these participants are required to perform their duties. These times, appended to tolerant noticeboards throughout our hospitals, seem to signify anything from "sending" (even if the patient to be sent for is six floors away) to the moment of knife to skin. Like Mr Datta, I have realised the second definition on only two occasions despite frequent monumental efforts to mobilise the system accordingly. It is one of the delusions of doctors that they alone control such events.

Behind the lack of precision lies a widespread inability to face certain practical facts. Time is required to transport a patient from the ward; to book him or her into the theatre suite; to establish rapport, monitoring, and anaesthesia; and, finally, to wheel the patient into the theatre, lift him across, and settle him under the drapes. The durations of these stages could profitably be measured and recognised in planning theatre time. The dangerous fiction that an anaesthetic is merely a two minute squirt on the way to the knife might then finally be put to rest and the surgeon given a reliable time at which to don his wellingtons.

There is a need for a statement from the Royal College of Surgeons and its faculty of anaesthetists on this matter.

KEITH L DORRINGTON

Nuffield Department of Anaesthetics,
John Radcliffe Hospital,
Oxford OX3 9DU

SIR,—It is regrettable that some statements made by Mr Pradip K Datta, should have been published.

Wick has a fairly small medical community whose members are easy to identify, which is particularly unfortunate as so many of the statements made by Mr Datta are untrue. It is simplistic to assume that a surgical operation starts when the knife strikes the skin. To have a set "knife in" time is a silly objective and certainly one that is way down the list of priorities of any anaesthetist. Getting the patient to operation adequately assessed (after discussion with the patient and colleagues), well prepared, and as stable as possible is surely more important. That this is achieved in daily surgical practice by all the relevant staff being in the hospital well ahead of time is regarded here in Caithness as self evident.

The suggestion that three minutes is the time that any reliable surgeon would take for a surgical consultation is ridiculous. In any case, even if the person Mr Datta refers to were half an hour late at two patients booked every quarter of an hour this would mean only four patients in the waiting room—surely a small waiting quota. In fact, however, the statement regarding a surgeon leaving home to drive 20 miles to a clinic at 9 30 am is not correct as far as Caithness is concerned.

It is typical of the exaggeration of Mr Datta's claim that he has started his list on time only twice in 19 years.

Usually we associate Mr Datta with light hearted, humorous articles. It is rather a pity that he has overstepped into unkindness on this occasion and that his article has degenerated into an unwarranted assault on his professional colleagues past and present.

W R ANTONIOS
IAN J BURNS
HUGH B CRUM
IAN H FARQUHAR

Caithness General Hospital,
Wick,
Caithness KW1 5LA

Testing the sense of smell

SIR,—While Dr Victoria Moore-Gillon's leading article (28 March, p 793) provided an admirable introduction to the new olfactory testing kits, she did not address the importance of using the right odours in the clinical testing of olfaction.

Many odours can be detected by trigeminal nerve endings in the nasal cavity. The clinical relevance of this was shown in a simple study in which many of the "standard" odours (peppermint oil, camphor, cloves) failed to detect known lesions of the olfactory (cranial nerve I) pathway.[1] By contrast, these were readily picked up by floral or musky odours—for example, musk ketone, exaltolide, linalyl acetate, coumarin—without any special equipment. The use of these odours also showed an unexpectedly high incidence of hyposmia or anosmia in patients with multiple sclerosis (68%). There was an almost inverse correlation between correct identification of the odours and their value as markers for impaired olfactory sensitivity, reflecting the extremely limited smell vocabulary of most people; this calls into question the importance of correctly identifying the odour in the new kits, as opposed to just detecting something.

If some hospitals do not elect to use the new "scratch and sniff" kits it is high time that they replaced the not only dusty but also inappropriate "smell bottles" with ones containing odours that really do test the first cranial nerve and do so with surprising sensitivity.

ANTHONY J PINCHING

St Mary's Hospital Medical School,
London W2 1PG

1 Pinching AJ. Clinical testing of olfaction reassessed. *Brain* 1977;**100**:377-88.

Hypochondriasis: an acceptable diagnosis?

SIR,—Dr Louis Appleby's review of hypochondriasis (4 April, p 857) is a welcome contribution to a problem that goes far beyond psychiatric practice. Though a primary syndrome undoubtedly exists, a purely descriptive basis for this conclusion is insufficient and the role of reassurance is complex. The mechanisms need to be clarified if successful treatments are to be devised.

Our work supports the view that anxiety, bodily symptoms, and illness related behaviour (of which reassurance seeking is just one example) are functionally interrelated in the maintenance of hypochondriasis.[1,2] In particular, illness behaviours contribute to increased perception and misinterpretation of and preoccupation with bodily symptoms. This mechanism closely resembles the self defeating and self maintaining behaviour of severe obsessional ritualisers. In hypochondriacal patients the illness related behaviours lead to short term relief of anxiety but long term increase in fear and preoccupation and the need to seek further reassurance.

We agree that some health workers have a negative view of hypochondriacal patients, often based on the patients' failure to respond to repeated reassurance. Paradoxically, repeated discussion of potentially anxiety provoking information exacerbates the patients' fears despite initial relief. New and relevant information given with great care is, however, helpful when it accurately explains the patient's frightening symptoms rather than attempting to argue the absence of feared illness. Dr Appleby suggests that detailed reassurance becomes more effective with time and reduces anxiety. This view contrasts with the very definition of the problem—that is, the failure of patients to respond to reassurance[3]—unless it is assumed that doctors do not give detailed reassurance to hypochondriacal patients. Reassurance based on inappropriate investigations, physical examinations, complex communications, and repeated clinic appointments may be extremely detailed but must not be confused with giving accurate, new, and relevant information that the patient understands.[2]

HILARY M C WARWICK

Maudsley Hospital,
London SE5 8AJ

PAUL M SALKOVSKIS

University of Oxford Department of Psychiatry,
Warneford Hospital,
Oxford OX3 7JX

1 Warwick HMC, Salkovskis PM. Reassurance. *Br Med J* 1985; **290**:1028.
2 Salkovskis PM, Warwick HMC. Morbid preoccupations, health anxiety and reassurance: a cognitive behavioural approach to hypochondriasis. *Behav Res Ther* 1986;**24**:597-602.
3 American Psychiatric Association Committee on Nomenclature and Statistics. *Diagnostic and statistical manual of mental disorders*. 3rd ed. Washington, DC: American Psychiatric Association, 1980.

Inadequacy of oleic acid in erythrocytes as a marker of malignancies

SIR,—We support the findings of Dr N Lawson and coworkers (21 March, p 769) and Dr O Søreide and colleagues (28th February, p 549) regarding the inadequacy of the stearic to oleic acid ratio in erythrocytes as a marker of malignancies, as proposed by Wood *et al*,[1] who suggested that this ratio might be used not only as a diagnostic marker in patients with colorectal cancer in particular but also to monitor recurrence.[2] We fully endorse the comments of Dr Lawson and colleagues about the methods of the two other groups of workers.

There are, however, further points to consider, including the influence of short term dietary intake as well as age and sex on the erythrocyte fatty acid membrane profile.[3,4] We are investigating these factors in patients with colorectal cancer, and our results will soon be published in full. The following results were presented to the Surgical Research Society last year.[5] We found that the erythrocyte stearic to oleic acid ratio in 21 patients with colorectal cancer (median 0·94; interquartile range 0·88-1·0) was similar to that in 21 patients with benign disease (0·92; 0·87-0·96). Unlike those in