and London¹⁰ have shown that antibodies to neutrophil cytoplasmic antigens can be detected and measured in the plasma of patients with Wegener's granuloma and vasculitis. This holds out the promise of a test that will help both in diagnosing the condition and in monitoring its activity.

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Resuscitating resuscitation

Sudden death is always disturbing, especially when it occurs in the young. Even more distressing is when the death could have been avoided given certain elementary skills in those present at the scene of the catastrophe. In hospitals such skills are taken for granted, but they are not always available, says a report published last week by the Royal College of Physicians.¹ Junior hospital doctors and nurses in many hospitals are not familiar with basic life support techniques, and few hospitals instruct their doctors and nurses in resuscitation. Regular revision classes are certainly not held, according to the report.

The committee preparing the report drew these inferences from published work rather than from any qualitative investigation of its own. If the allegations are correct then the failure must be remedied rapidly as there can be no excuse for doctors being unable to respond quickly, effectively, and humanely in an emergency. The report gives clear guidelines for training and for the organisation of resuscitation services in hospitals, the community, and in specialised areas. Its recommendations on the training of medical students, young doctors, and nurses in life support methods should be adopted as obligatory elements of their training. All National Health Service staff in regular contact with patients should receive instruction in basic life support techniques using training mannikins, and they should attend regular refresher courses.

Every hospital should have an on call resuscitation team skilled in all the disciplines of advanced life support; this team will have to integrate with those on site who start first aid. The resuscitation team must have a designated leader to take complete responsibility to avoid confusion—and therein lies the basic problem. In Britain crash teams consist most often of junior doctors of equal rank, and it is unusual to have

a member who is sufficiently senior to take charge and carry the responsibility.

The recommendation that each hospital should have a formally constituted resuscitation committee is an important idea that should allow the introduction of audit and the establishment of clear operational guidelines. The appointment of district resuscitation training officers would go some way to ensuring the provision of continuing education and the maintenance of standards, which the report recognises as important. The officers' duties would include not only organising basic training and refresher courses for hospital staff but also training staff in health centres, dental surgeries, factories, schools, large shops, and offices in basic resuscitation techniques. Training ambulancemen along the lines of North American paramedics and paying them for the skills they achieve would be welcomed both by the ambulance service and by the general public. The ambulance makes an ideal resuscitation vehicle, and it should be equipped with "intelligent" defibrillators.

The college committee is to be congratulated on producing such a succinct report. But I regret that no anaesthetist was included since anaesthetists have so often taken the lead in developing resuscitation and intensive care services. It is also a pity that more space was not devoted to the ethics of resuscitation for while it is bad practice to fail to resuscitate it is equally bad to treat aggressively those who should be allowed to die peacefully. For many doctors this is the most difficult assessment to make.

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Coventry: a no drinking-driving city by the year 2000?

Coventry City Council, Coventry Health Authority, and Coventry and Warwickshire Alcohol Advisory Service are planning to make Coventry a no drinking and driving city by the year 2000. In 1985, 25 people died on the roads in Coventry, and eight of these deaths could be attributed to alcohol. In the same year we estimate that 140 injuries on the road were related to alcohol. National action will, we believe, be necessary to reduce alcohol associated injuries on the roads, but local action will also be important.

In the autumn of last year we brought together the organisations in Coventry who will have a part to play in making Coventry a no drinking and driving city. We included those with vested interests in transport and alcohol. The recommendations of the seminar have been endorsed by the city council's public works and consumer protection committee. Dr James Dunbar of the Tayside Safe Driving Project told the seminar about his project and about the Finnish experience of how random breath testing and reducing the blood alcohol concentration above which driving is illegal to 50 mg/100 ml led to a fall in road traffic accidents (p 101). The meeting supported the idea of a lower limit and random breath testing for Britain. It also wanted to see more

resources for alcohol rehabilitation programmes for drink driving offenders and publicity about the dangers of drink driving at all times of the year, not only at Christmas.

We are most concerned with local action. We have devised a "Coventry says no to drink driving" logo and are approaching local groups that should be able to help—for example, taxi firms, insurance companies, and soft drinks manufacturers. We want motor manufacturers and dealers to distribute leaflets on drinking and driving with the cars they sell. The Royal Automobile Club has offered to circulate its members in Coventry with information. We also want publicans and off licences to display the logo (perhaps on beer mats) and supply information. Local landlords will, we hope, participate in a "walk to your local" campaign. Local magistrates may choose to limit the number of new licences that they grant, and the police have a part to play in changing prosecution practices. The local alcohol advisory service and the probation service hope to provide more alcohol rehabilitation for convicted drivers. Unfortunately, the West Midlands Passenger Transport Authority has "rescheduled" late night bus services, making it more difficult for people to drink but not drive. Providing late night transport once again is being considered as one way of preventing drink related accidents and violence.

We have a long way to go to achieve our aim of making Coventry a no drinking and driving city by the year 2000, but we hope that other areas will consider adopting similar schemes. Increased local action to combat drinking and driving might create irresistible pressure for changes in national legislation.

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Surgery of morbid obesity

The Americans call the surgery of morbid obesity bariatric surgery, and it has evolved rapidly because of the failure of dietary treatment to control massive obesity. About 34 million Americans aged 20 to 75 are overweight, and no fewer than 12.4 million are severely overweight. The numbers are increasing, particularly among the black population and those in the lower socioeconomic classes.¹ Severe obesity—that is, a body mass index (weight divided by height squared) over 35—is associated with a higher mortality. Those with a body mass index over 40 find it hard to obtain normal employment or to get life insurance, and with such obesity weight loss by dietary restriction is extremely difficult. It requires rigorous energy restriction for more than a year and for this reason is rarely successful. Radical solutions have thus been proposed, the simplest of which is dental splinting. It is successful in producing weight loss, but once the splint is removed few patients manage to maintain their lower weight.

Bariatric surgery achieves weight loss by restricting food intake and in some operations by causing fat malabsorption. Two main methods have been developed in the past 20

years—gastric and intestinal bypass surgery. These operations also make it more difficult to regain the lost weight by preventing overeating. Intestinal bypass, which was extremely popular during the 1970s, was achieved by excluding varying lengths of the small intestine and sometimes anastomosing the blind loop to the gall bladder. Gastric bypass has developed from a classic gastrointestinal bypass based on a Bilroth II operation to varying forms of gastric partition that reduce the gastric channel to the duodenum.

A sequential study from 1972 to 1982 suggested that reasonable weight loss occurred with all the operations.² A 13 year review of jejunoileal bypass on 180 patients in one unit showed that this procedure was a most effective operation for morbid obesity and that with experience it could be performed safely.³ Unfortunately, the complication rate and difficulty of maintaining satisfactory follow up on many young patients made it unacceptable for performing on a large scale, although it is easily done and can be reversed without difficulty. Gastric bypass was associated with far fewer serious long term complications but was difficult to reverse.

Various forms of gastric bypass have been described in the past five years, but the present most favoured method is the vertical banding gastropasty devised by Mason.⁴ Several reports have cited failure to lose weight after gastropasty and described corrective operations, but more worrying is the failure to report complications. There are, compared with jejunoileal bypass, few long term studies in depth of gastropasty. Thus a report of gastritis and gastric dysplasia in four fifths of 28 patients who had undergone an Alden modification of the gastric bypass procedure between 1979 and 1981 is important.⁵ In this operation the stomach is cross stapled and an anticolonic loop gastroenterostomy is performed with a 30 ml upper gastric pouch. Gastric dysplasia is of great concern and careful follow up becomes imperative, as it is after gastric surgery for peptic ulceration because of the increased incidence of cancer.

No single surgical procedure will be satisfactory in every case and none can be applied by the occasional practitioner. What is the alternative? Bjorvell and Rössner have reported a four year programme of treatment combining standard techniques such as behavioural modifications, nutritional advice, and readmission on relapse with surgical treatment.⁶ One third of their patients had their jaws wired, and of the 107 entered into the trial no less than one third had left the programme after four years. The mean loss of weight was 11.7 kg or 27% of the excess weight before treatment. Those who had their jaws fixed lost more weight than those treated medically, but they regained more weight. As in many other trials, patient motivation was poor.

When results are so poor should surgery for morbid obesity be reserved for those in danger of dying? Can such a group be defined? Should body image be a criterion for surgery, or should surgery be advocated for those with appreciable hypertension, maturity onset diabetes, or hyperlipidaemia? Now that bariatric surgery is here to stay, we must examine the achievements before attacking new goals; certainly, we need long term trials. Meanwhile, in our unit we are resting.

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