(p. 188) a letter appears signed by 120 doctors from the registrars' room at a leading teaching hospital. It would be interesting to know if a reasonable proportion, or even if 1%, of these doctors so "concerned" and "alarmed" at their prospects are being trained in geriatrics or psychogeriatrics—where the prospects of attaining consultant status are relatively good. Without an adequate supply of suitably trained registrars consultant posts in geriatrics will continue to go begging.

When one considers that perhaps half the total hospital population is aged over 65 and that the proportion is increasing, it is surprising that there are still large regions where little or no training is undertaken in geriatric management. There is reason to believe that the Ministry of Health is aware of this increasing need, but is this equally true of academic advisers who must compete at regional level for available funds? Given the present advisory structure it is pertinent to ask whether the need will, or can, be met without the establishment of university departments of geriatric medicine.—I am, etc.,

R. W. PARNELL.

Highcroft and Summerfield
Hospitals,
Birmingham.

Spout Cervical Oesophagostomy

SIR,—One of the distressing terminal features of malignant obstruction of the oesophagus is the patient's inability to swallow his saliva, which consequently has to be spat out frequently and leads to drooling and overspill into the respiratory tract, causing coughing and recurrent pneumonitis.

In association with gastrostomy, cervical oesophagostomy effectively deals with the problem of the saliva and, furthermore, enables the patient to eat and drink on a "sham feeding" basis. The management of a cervical oesophagostomy as usually performed can be a trial, as it is difficult to arrange an appliance on such a mobile portion of the anatomy and maintain a watertight fit on a flush type stoma, with consequent risk of excoriation of the skin.

To construct a cervical oesophagostomy with a spout overcomes this difficulty, in that efflux from the stoma drops clear of the skin into a suitable receptacle. A rubber bag held in place by linen tapes tied around the neck, or a disposable polyethylene bag with an adhesive flange, are such receptacles (Fig. 1). In constructing a spout cervical oesophagostomy the oesophagus should be mobilized as far distally as possible from an anterior sternomastoid neck incision on the left side and the oesophagus transected. It appears to be unnecessary to suture close the distal

FIG. 2

cut end, as to do so effectively is difficult from a cervical incision and no penalty arises from leaving it open, provided a generous drain is placed down to it into the posterior mediastinum. The mobilized proximal oesophagus is brought out of the cervical wound, turned back on itself, and the cut edge sutured with interrupted sutures to the skin edge of the incision (Fig. 2). At this level the intrinsic blood supply of the oesophagus is adequate to sustain a spout of at least 2 in. (5 cm.) projection. A disposable adhesive polyethylene bag is immediately applied.

The patient is then enabled to eat and drink as he wishes. Periodically the receptacle is emptied and its contents either disposed of or used after homogenization in the gastrostomy feeds.—I am, etc.,

LAURENCE TINCKLER.

Western Infirmary,
Glasgow W.1.

Edinburgh Transplantation Unit

SIR,—On 8 July the *Guardian* published a letter signed "Hospital manager" criticizing the spending of public money on what the writer referred to as "the expensive new heart transplant unit at Edinburgh."

It seemed clear that this letter could only refer to the Nuffield Transplantation Surgery Unit, and if this were the case it seemed to me that the author of the letter in the *Guardian* was misinformed and his criticism was quite unfair. I therefore wrote a letter to the *Guardian* in reply pointing out firstly that the Nuffield Transplantation Surgery Unit is not a heart transplant unit, but has been built to meet the needs of a wide variety of patients who are especially at risk as regards infection, including *inter alia* organ transplant recipients, patients receiving immunosuppressive treatment on account of autoimmune disease, patients with certain types of cancer, and patients who have been accidentally exposed to ionizing irradiation; and secondly that the Unit was built with money provided in the form of a generous

grant by the Nuffield Foundation. A fortnight after I had sent my letter to the *Guardian* it had still not been published. In reply to an inquiry the editor stated that it was in type but he could not promise that it would be published.

It seems to me irresponsible for a widely read daily paper to publish a letter which is quite misleading, and then fail to publish promptly a reply setting out the true facts of the situation. It also seems odd to me that so many people who are lucky enough to have healthy kidneys and other organs seem to resent money being spent to save the lives of those who have not, yet comparatively few object to large sums being spent in searching for yachtsmen and mountaineers who have deliberately chosen to accept the risks inherent in their particular sport. The cost of such searches is sometimes defended on the ground that they provide important experience for the rescue crews; what is often overlooked is that research in one field of medicine often leads to major advances in another. Research in transplantation, for example, has played a major part in the development of modern immunology, which in turn holds promise of major advances in the treatment of many diseases, including rheumatism and cancer.

There are many ways in which public money is wasted which are only too obvious. As a doctor, and also as a sailor (albeit a modest one), I cannot accept that saving life is one of them. Surely no man of good will, certainly no Christian, would deny the truth of Donne's assertion "... any mans death diminishes me, because I am involved in Mankind."—I am, etc.,

MICHAEL WOODRUFF.

Department of Surgical Science,
University of Edinburgh,
Edinburgh 8.

Transferable Resistance

SIR,—Within the past two years much attention has been drawn to the possible epidemiological significance of the "resistance transfer factor," an episomal component present in certain strains of enteric Gram-negative bacteria. The arguments that this episome can be transferred from resistant non-pathogenic organisms to non-resistant pathogens and can thus prejudice the usefulness of antibiotics in therapy have been presented elsewhere with varying degrees of vehemence.¹⁻³

Rather than reviewing these arguments, I shall recount some experiences that were gained during the use of antibiotics as animal feed additives. This procedure has been adopted widely in many countries throughout the world since 1950^{4,5} when an antibiotic (chlortetracycline) was first introduced into the feeding of farm animals in the U.S.A. Chickens, pigs, and calves responded well to antibiotic feeding in terms of increased growth. Bloody diarrhoea was rife among pigs in the Middle West; it disappeared promptly when they were given food containing small amounts of chlortetracycline. It was my opinion in 1950, expressed verbally but not in publications, that bacterial resistance to antibiotics would rapidly develop in farm animals as a result of feeding chlortetracycline, and that the use of antibiotics

FIG. 1