Diverticular Disease of Colon

SIR,—It was heartening to see in Mr. N. S. Painter's article on diverticular disease (24 August, p. 475) his allusion to our modern refined diet in the aetiology of this condition.

In this connexion, and with further reference to our previous letter (2 March, p. 579) raising the question of intestinal transit times in Africans living on unrefined maize, a small sample of these transit times has now been completed, through the kindness of Dr. J. P. Bostock, radiologist to the Eshowe and Empargeni Hospitals in Zululand, who has been helped by Dr. W. E. G. Butler, of the latter hospital.

Standard doses of barium were given to two groups of these tribal Africans: (1) Six farm labourers on their usual diet of unrefined maize; and (2) six patients in the wards of the Empargeni Hospital, on a similar diet, but with a slightly higher protein content. Both groups were subjected to daily radiographic examinations to study the transit of the contrast medium. The results are shown in the Table.

Number of Subjects with Barium Still Visible

Group	At 24 Hours	At 48 Hours	At 72 Hours
6 farm labourers	3 (trace)	Nil	Nil
6 patients ..	3 (small amount)	3 (trace)	Nil

It will be noted that in 3 farm labourers the meal was passed inside 24 hours.

These Africans, as stated in our previous letter, pass two characteristic soft stools a day. Meanwhile Dr. Bostock comments with special emphasis upon the differences seen in the transit times in local Europeans in the Empargeni area, where the presence of barium is almost always detectable up to and even over five days. These Europeans live on the usual diet of the South African white—that is to say, one high in refined carbohydrates.

All the foregoing bears out the contention in our letter that there is a big difference between the *normal* transit times in Westernized peoples living on refined carbohydrates, in whom intestinal stasis is a very common finding, and the *natural* transit times, as exemplified above; and that though diverticulosis subjects can easily be understood, for the reasons we gave, as having shorter transit times than the normal, as recently shown by Manousos, Truelove, and Lumsden,[1] they do not have shorter transit times than the natural. This is indeed in close accord with facts realized long ago. Thus, in the paper by Spriggs and Marxer,[2] quoted by Mr. Painter, it was found that in 100 diverticulosis patients over half complained of constipation, and that of the remainder who did not complain many were also constipated; but it was also found that the 100 control patients without diverticulosis were even more constipated.—We are, etc.,

G. D. CAMPBELL.
T. L. CLEAVE.

Fareham, Hants.

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1 Manousos, O. N., Truelove, S. C., and Lumsden, K., *Brit. med. J.*, 1967, 3, 760.
2 Spriggs, E. I., and Marxer, O. A., *Quart. J. Med.*, 1925, 19, 1.

Pain in the Face

SIR,—I was delighted to read Dr. John Penman's letter (24 August, p. 498) concerning alcohol injection of the trigeminal sensory root and commenting on Professor Henry Miller's article (8 June, p. 577). In this centre I am now performing injections under radiological control each week, and so far this year our patients' ages have ranged from 47 to 82; all have taken carbamazepine at one time or another. It is particularly the aged who are greatly distressed by tic douloureux, and we find it gratifying to be able to offer these patients complete relief of their pain by a procedure to which age and frailty are never a contraindication. It would be sad if these patients were denied this relief simply because the procedure had "lost its vogue."—I am, etc.,

JOHN GARFIELD.

Wessex Neurological Centre,
Southampton General Hospital,
Southampton.

SIR,—The purpose of my brief letter (27 July, p. 251) was to draw attention to the fact that cranial arteritis should be considered in the differential diagnosis of atypical facial pain.

I did not discuss treatment. May I assure Mr. Martin Joyce, in reply to his letter (24 August, p. 498), that I am fully aware of the dangers of ophthalmic complications in cranial arteritis and of the importance of early diagnosis and high-dosage steroid treatment. Mr. Joyce seems to be under the impression that I advised against treatment of these cases, but this was certainly not implied in my letter.—I am, etc.,

R. W. BARTER.

Princess Mary's Hospital
(Rehabilitation),
Margate, Kent.

Intractable Pain

SIR,—The experience quoted in the leading article on intractable pain (31 August, p. 513) corresponds to that at the Liverpool Regional Neuro-surgical Centre Pain Relief Clinic. It was noted with surprise that no mention was made of the percutaneous electrical cordotomy in the relief of the intractable pain of cancer.

Unlike the open surgical cordotomy the electrical cordotomy is not a major surgical procedure and can be undertaken on the chronically ill and elderly. The mortality is low and the morbidity very considerably reduced. In addition the technique is easily repeated and it can deal with pain in the arm. The percutaneous electrical cordotomy is the preferred method of treatment of cancer pain at the Liverpool Regional Neurosurgical Centre, where over 100 electrical cordotomies have now been done.

The percutaneous electrical cordotomy is widely accepted in the neurosurgical centres of north America, and at the Harvey Cushing Meeting in Chicago last April a whole morning seminar and several papers were devoted to the subject. There is now an adequate bibliography.[1-5]—I am, etc.,

S. LIPTON.

Pain Relief Clinic,
Regional Neurosurgical Centre,
Walton Hospital,
Liverpool 9.

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1 Lin P. M., Gildenberg, P. L., and Polakoff, P. P., *J. Neurosurg.*, 1966, 25, 553.
2 Lipton, S., *Brit. med. J.*, 1968, 2, 210.
3 Mullan, S., Hekmatpanah, J., Dobben, G., and Beckman, F., *J. Neurosurg.*, 1965, 22, 548.
4 Rosomoff, H. L., Carroll, F., Brown, J., and Sheptak, P., *J. Neurosurg.*, 1965, 23, 639.
5 *World Medicine*, 1968, 3, No. 23, 35.

Thermography in Occlusive Cerebrovascular Diseases

SIR,—I was interested in the paper by Dr. C. Mawdsley and others (31 August, p. 521). Clearly thermography could be of use in the management of some patients, but there is the serious danger of those with small ulcerating carotid plaques not having arteriograms because of normal thermography.

Incidentally, Toole[1] has claimed that the temperature difference can be shown with an ordinary thermometer.—I am, etc.,

W. REX MORRIS.

Newcastle Regional
Hospital Board,
Newcastle upon Tyne.

REFERENCE

1 Toole, J. F., *Trans. Amer. neurol. Ass.*, 1965, 90, 126.

Our Hospitals

SIR,—During the past years, as bureaucracy in medicine has grown, there has been a development of a new yardstick to apply to medical services in this country, and it is of course economy. The view now expressed by our lay administrators is that no hospital is economical below the size of fifty beds and must be closed. The part a hospital plays in maintaining the medical care of the town is apparently of trifling importance.

A theoretical norm of financial success appears to have been set, and, despite the fact that there are other factors to be taken into consideration, in the future many hospitals which have been built and paid for by the townsfolk are to be scrapped as a result of the irresponsible application of this strict criterion. The size of new hospitals being built in growing areas of the country depends on a series of figures that may or may not be accurately forecast to cover the needs of an area. There will be many examples in the future of new hospitals being built, presumably to take over the care of the patients who formerly went to small hospitals, which finally are found to be inadequate in size. It would be far better to build new hospitals and allow them to function for five years before precipitously closing small hospitals.

It behoves the general practitioners and hospital doctors in Britain to maintain these hospitals until it can clearly be shown that they are of no use to their respective towns.—I am, etc.,

JOHN SHIPMAN.

North Herts Hospital,
Hitchin, Herts.