Correspondence

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Surgery for Duodenal Ulcer

SIR,—In your leading article (8 August, p. 295) we were strongly urged to abandon the concept of patients "earning" elective surgical treatment for duodenal ulcer, and in addition one or two other long-held beliefs were assailed. The principal evidence on which the traditional concepts were to be discarded was the admirably thorough review of postoperative patients reported by W. P. Small and his colleagues.¹ I think, however, that there might be just a little hesitation before concluding that the findings of the Edinburgh series conclusively prove that patients with a short history of duodenal ulcer dyspepsia do just as well as those with longer histories after operation, and that the results of surgery are not correlated with length of history, age of the patient, or severity of symptoms. Although a considerable amount of valuable data has been collected by Mr. Small and his colleagues the observations were all made retrospectively in groups of patients which were not homogeneous. It is, therefore, possible that some inaccuracies in recall of the preoperative information may have arisen, and that possibly significant correlations between the pattern of clinical results from the operation and pre-operative factors may have become submerged in this uncontrolled trial.

Indeed, a randomly allocated controlled

trial of equal numbers of patients having truncal vagotomy with either a pyloroplasty or a gastrojejunostomy in the last four years in Glasgow² has shown significantly poorer clinical results, graded by a modified Visick classification, in those with short histories and younger patients, and those with poor results tended to have more preoperative complications such as haemorrhage or perforation. From a computer-based analysis of a wide range of variables, all recorded prospectively, these indeed were the only factors which showed a significant correlation with poorer postoperative clinical results.

It might seem wise, therefore, to await the objective assessment of other prospective controlled trials of uniform material before making a final definite conclusion on whether there is a strong case for the more widespread use of surgical measures at an early stage in the course of duodenal ulcer as has been strongly advocated by your leading article.—I am, etc.,

IAIN E. GILLESPIE.

Department of Surgery,
Western Infirmary,
Glasgow W.1.

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- Kennedy, F., Gillespie, I. E., and Kay, A. W., *British Journal of Surgery*, 1969, 56, 626.

Shellfish Poisoning

SIR,—I have read with interest your valuable leading article on "Shellfish Poisoning" (1 August, p. 240). I have worked for several years on the actions of paralytic shellfish poison and similar poisons¹ and I would like to add a brief comment.

You stated, quite correctly, that bivalve shellfish accumulate the paralytic shellfish poison called "saxitoxin" when they feed on certain dinoflagellates. Saxitoxin appears to originate in the dinoflagellate *Gonyaulax catenella* and is the substance responsible

for the outbreaks of paralytic shellfish poisoning that have been a recurring problem along the Pacific coast of North America. However, there has been some evidence that the paralytic shellfish poison acquired by scallops from *G. tamarensis* differs from saxitoxin.² The mussels which caused the 1968 outbreak in Northumberland became toxic after *G. tamarensis* had bloomed in the offshore plankton. With the assistance of Professor R. B. Clark, Dr. P. C. Wood, and the staff at the Ministry of Agriculture, Fisheries, and Food station at North Shields I obtained samples of the toxic mussels from Holy Island. Some saxitoxin was extracted from these, but most of the paralytic toxicity was due to a different poison. This substance acts like saxitoxin, causing a widespread paralysis (including respiratory failure) by a peripheral action on skeletal muscle and on nerve conduction. Its chemical composition is not yet known, but it appears to be a small and relatively heat-stable molecule like saxitoxin. The detailed results of this work have recently been submitted for publication.

Artificial respiration, in combination with general supportive measures, is the only treatment for paralytic shellfish poisoning that is likely to be effective at present. I think it important that the preventive monitoring and control measures should be continued, including the routine examination of offshore plankton for the presence of *Gonyaulax* and other potentially dangerous organisms.—I am, etc.,

MARTIN H. EVANS.

Agricultural Research Council,
Institute of Animal Physiology,
Cambridge.

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