The recent report of the committee headed by Sir John Peel² is an admirable one, but I think it is based on inadequate knowledge of the real situation. I imagine that the report is based on the standard of teaching hospitals and it should be realized that these represent a minority of hospitals where good obstetrics is practised; in other places in my own experience the standard can be less than satisfactory. I submit that the statement that we should aim for 100% hospital confinement is quite wrong. Surely our ultimate aim should be a reduction in mortality and morbidity? There is certainly no convincing evidence that this would be achieved by 100% hospital confinement. Most women who have experienced both home and hospital will prefer home delivery, particularly as they all know that the great majority of confinements are uncomplicated. The report states that one of the reasons for the failure to achieve 100% hospital confinement in this country has been partly due to tradition, and that we have not emulated certain other countries in this respect. Is there convincing evidence from any of these countries that their results are better? I think not.

The idea of unifying the obstetric service is an excellent one, but the statement that domiciliary obstetrics should be organized from the hospital seems ill-advised. Surely it would be much better to have increasing time for expert consultation at family doctor clinics and in the patient's home. Most hospital facilities can be made available in the patient's home without much difficulty. This would have many advantages, not the least being a decrease in the amount of infection and an increase in successful breast feeding.

You suggest that the proposed new system might deteriorate into a factory production line. I have evidence that this is already happening.

If my ideas are sound and my experience valid, the subject is certainly of political importance as the new proposals would obviously increase the cost of the N.H.S.

Above all we should realize that obstetrics is as much an art as a science, and that the mother's choice of where she will have her baby—other things being equal—is of primary importance.—I am, etc.,

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Anaesthetic Services

SIR,—Dr. T. H. Taylor and colleagues' researches into this subject (4 July, p. 39) have provided, for the first time, concrete evidence of the situation in this country.

It seems no exaggeration to state that, on a national scale, obstetric patients are being provided with a second, or even third-rate, standard of clinical care so far as anaesthesia and neonatal resuscitation are concerned. The effect of this in terms of morbidity is incalculable; the result

in terms of mortality (in respect to mothers, although not in respect to infants is displayed in the chastening figures contained in the most recent *Report on Confidential Enquiries into Maternal Deaths*.¹ I have dealt at some length with aspects of this subject,² and you referred to this in your recent leading article (23 May, p. 437).

During the past year a group of consultant anaesthetists (now approaching one hundred in number), having a special interest in obstetric problems, have decided to form the Obstetric Anaesthetists' Association (O.A.A.). After well-attended meetings in Liverpool, Birmingham, and London a steering committee (of which I have the privilege of being chairman) has been formed which will present plans for formalization of the association at its next general meeting in Glasgow in October. Our concern is not only with the details of clinical care of mothers and infants but also with the adequacy of staffing of obstetric units by anaesthetists.

There are two aspects to the question of staffing in our opinion: the provision of adequate on-the-spot trainee anaesthetist cover, with enough consultant supervision of the training of juniors; and the maintenance of satisfactory standards of equipment for anaesthesia and resuscitation. Most obstetricians, paediatricians, and anaesthetists have recognized for many years that the work of an anaesthetist in an obstetric department is of a specialized nature, demanding training and experience beyond that provided by the basic involvement in the work of a general hospital. The responsibility for this work is great, and it is highly undesirable that unsupervised and virtually uninstructed junior anaesthetists should have to bear it any longer.

To ensure a better and safer standard of patient-care in obstetric units encouragement must be given to the anaesthetic supervision of both mothers and infants by senior and experienced practitioners who have a contractual commitment to the work. It is ludicrous that within the 344 hospitals surveyed by Dr. Taylor only 222 consultant anaesthetist sessions were devoted to obstetric work, and that in no less than 242 of these hospitals there was no consultant with an official commitment to this important area of medicine.

Members of the Obstetric Anaesthetists' Association fully appreciate that a sudden increase in the number of consultant anaesthetist sessions available in the United Kingdom would throw considerable stress on other aspects of the anaesthetic services. However, members urge that remedial measures be undertaken with some urgency, and are eager to consult, through their representatives, with N.H.S. administrators, and with representatives of the general bodies of anaesthetists, obstetricians, and paediatricians to see how progress may most rapidly be achieved.—I am, etc.,

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Soccer Supporters' Wrist

SIR,—I wish to draw attention to the occurrence of hyperextension wrist injuries to spectators at association football matches and to the characteristic manner in which they are sustained. These observations are the results of a three-year retrospective study of wrist injuries sustained by soccer supporters in Manchester who were treated at this hospital.

During the period of study seven cases of bony injury to the wrist were seen in football supporters. All were male and aged between 12 and 18 years. The injuries included three cases of greenstick fracture of the distal radius and ulna with dorsal angulation, three cases of fracture-separation of the distal radial epiphysis (one displaced, two undisplaced), and one case of fracture-separation of the distal ulnar epiphysis. All were single closed injuries.

Though this hospital is situated close to both the Manchester City and the Manchester United Football Club grounds, it is possible that many more such injuries occurred but were either treated at other Manchester hospitals or were sustained by visitors, who subsequently presented themselves at their local hospitals. It is interesting that on only one occasion was the attendance at which patients sustained these injuries less than 60,000.

The mechanism of injury in all cases was similar. Each patient stated that he had been standing immediately behind a crowd barrier with his hands on the upper transverse tubular steel bar, when a forward thrust of the crowd down the slope of the terracing behind him applied a crushing force to his shoulders and a forced hyperextension of his wrists. At one match three friends standing together received these injuries simultaneously.

Although it appears likely that similar cases of such injuries are being treated in accident departments in other hospitals I have been unable to find a description of this mechanism of injury in the literature.—I am, etc.,

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Influenza Vaccination

SIR,—For the past ten years or so we have vaccinated council staff against influenza in the autumn. It has not been possible accurately to assess the value of the procedure, but last winter's figures are of some interest though the number are small.

Difficulties arose in obtaining vaccine against the Hong Kong strain in the autumn of 1968, and a monovalent vaccine did not arrive until January 1969. As the expected epidemic had not yet materialized it was decided to vaccinate those who were willing. In the autumn of 1969 vaccination again was offered with a bivalent vaccine. In the first 25 vaccinated persons there was an unduly high proportion complaining of minor side effects, and the dose for the remaining 87 was reduced from 1 ml. to 0.5-0.75 ml., and no further trouble was experienced.

During the period 16 December 1969 to 27 January 1970 an outbreak of influenza occurred as part of the national epidemic with a peak locally in early January, when

claims for sick benefit reached a weekly figure of approximately 450% above the seasonal average. Strains of the Hong Kong variant of influenza virus A2 were isolated in the area. Returns from councils of absence owing to illness, believed to be influenza, during December and January were as follows.

Unvaccinated	164	Off sick	41
Vaccinated once only	27	Off sick	7
Vaccinated twice	85	Off sick	nil

From this it will be seen that there is no difference in the absentee rate of those who were unvaccinated from those who received one dose only in November 1969. In the case of those who received two doses there were no absences, and this is statistically significant. Although one cannot draw any firm conclusions because of the small number who received one dose only, and in 23 a reduced dose, it seems prudent to advise an initial course of two doses in the previously unvaccinated and where there has been a significant change in the strain of the A2 virus.—We are, etc.,

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Thromboembolic Complications in Myelomatosis

SIR,—I was very interested in the article by Dr. D. Catovsky and others drawing attention to the thromboembolic complications in myelomatosis (22 August, p. 438). It is becoming apparent that thromboembolic complications in this disease are more common than has been hitherto believed, although the views of Sanchez-Avalos *et al.*¹ that they are nearly as common as the haemorrhagic complications appear to be an over-estimate. This is supported by a number of recent studies in which thromboembolism had not been mentioned, while haemorrhagic complications featured prominently,²⁻⁵ as well as by personal observations, the incidence of haemorrhagic complications being twice as high as that of thromboembolism.⁶

As to the role of amyloidosis in causation of these complications the position appears to be less clear. Although thromboembolic complications are not uncommon in patients with secondary or primary amyloidosis, it is of interest that in myelomatosis associated with amyloidosis thromboembolic complications have not been encountered before, while haemorrhagic complications are relatively common.² This has been supported by the finding of severe haemorrhagic complications in three out of seven patients with myelomatosis associated with amyloidosis, while thromboembolic complications were not observed.⁶ The presence of amyloidosis has not been mentioned by Sanchez-Avalos *et al.*¹ in their cases of myelomatosis with thromboembolic complications. The disturbances in the coagulation mechanism in myelomatosis are very complicated, being affected by numerous factors,^{1,3} but it appears that in this disease there is a disturbance in the proportion of coagulation factors, which may easily shift

the balance either way producing haemorrhagic or thromboembolic complications.

It should also be remembered that patients with myelomatosis are often elderly and bedridden, and thus more liable to thromboembolic complications.—I am, etc.,

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Surgery for Duodenal Ulcer

SIR,—It was at the recent World Congress of Gastroenterology at Copenhagen that my colleagues and I first became aware of Professor I. E. Gillespie's disagreement with our findings. Unfortunately, the data provided in the abstract to which Professor Gillespie refers in his letter (29 August, p. 520) are insufficient to allow us to comment on their numerical significance. Perhaps, however, I could clarify some points that he raises regarding our own work.¹

It is true that ours is not a randomly-allocated controlled trial performed with the aid of computer-based analysis. Such a trial was not our intention, nor could it ever be, for this would mean the random allocation of new ulcer patients to immediate and delayed surgery, and who could ethically deny early surgery to the stenotic or bleeder?

It is misleading to suggest that our observations were "made retrospectively" in the sense that we drew on past information culled from dusty archives. The first group of patients had been seen and graded at frequent intervals over the years at follow-up, and all the details used in our study had been checked repeatedly. In this sense our records were current. It was during this work that we came to realise that many patients wished that "they had had the operation years ago." In a follow-up clinic this is one of the many jolts to preconceived ideas that comes from that salutary but apparently unacceptable backward look. In our case, it led us to the prospective survey of an unselected second group of patients. These were reviewed blindly and were independently assessed both physically and psychiatrically at six-monthly intervals and we reported our findings at 2½ years in those patients who came to surgery.

The pattern was the same as in the original group. Earning was useless in predicting the result of operation. Being unmatched, it is true that two series of patients differed in many ways and were certainly not "homogeneous." But this very fact enhances rather than detracts from the statistical significance of the finding common to both groups—that neither age nor duration of symptoms affects the result of operation.

It is wrong to suggest that ours is a plea for headlong recourse to early surgery. We

have sought to improve the results of surgery by pointing to some long-held misconceptions and to the inadequacies of present methods of selection. To this end, we advocated painstaking assessment, both physical and psychiatric, of every patient from the time of admission to hospital. It follows that, once recognized, the patient with that kind of ulcer which needs surgery could reasonably be offered, as stated in your leading article (8 August, p. 295), "relatively early operation."—I am, etc.,

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REFERENCE

- 1 Small, W. P., *et al.*, *Gut*, 1969, **10**, 996.

SIR,—I was interested to read the article (15 August, p. 372) by Mr. H. Burge and others on recurrent ulceration after vagotomy and drainage with electrical stimulation test.

Although in the vast majority of cases the recurrence of ulceration is due to incomplete vagotomy other factors can, in some few cases, account for recurrence. In the 10 cases described by Mr. Burge and colleagues the recurrences were due in all cases to incomplete vagotomy. The authors then infer that by use of the Burge electrical stimulation test all the vagi nerves including the branches can be detected and removed, so making the vagotomy complete. This indeed may be true, but what I fail to understand is how Mr. Burge and his colleagues can find these minute branches even after obtaining a positive response with the electrical stimulation machine. These radicles are virtually impossible to see unless some sort of indicator such as leucomethylene blue dye is applied to the surface of the oesophagus, when the branches will show up as fine blue-black tendrils, which can then be picked up easily and removed, thereby making the vagotomy complete. When recurrence of ulceration occurs following vagotomy it is mainly due to failure to remove these radicles and not the main trunks.

I should like to point out that the application of the leucomethylene blue to detect the vagi and its branches is not a test for completeness of vagotomy—it is an aid to seeking out the vagi branches, and it thereby contributes to the effectiveness of the operation.

In Case 8 of Mr. Burge's series he states that recurrence was due to failure to divide the left gastric artery. Most of the gastric branches of the right or posterior vagus nerve reach the stomach as a plexus surrounding the left gastric artery and therefore it is necessary, in all cases of vagotomy, to divide the left gastric artery. Furthermore unless the left gastric artery is divided it is impossible to detect those branches of the posterior vagus nerve which arise higher up and run down the right border of the oesophagus towards the body of the stomach. Here again unless the leucomethylene blue dye is applied to the oesophagus (after the left gastric artery has been divided) these tiny tendrils are impossible to find. In Case 10 Mr. Burge admits