Other Indications

STUDENT: Are there any other indications for the use of the biguanides than in the obese diabetic patient?

DR. WOOD: They are sometimes useful in the management of the secondary or primary failure of the sulphonylureas.

DR. STOWERS: Yes. There is a true synergism of hypoglycaemic action of the sulphonylureas and biguanides, which exert their effects quite differently, but it is useless to give this combination to diabetics who are prone to ketosis. These people require insulin.

There are a few so-called "brittle" insulin-dependent diabetics who find it exceedingly difficult to avoid disabling hypoglycaemia. The cause of this can usually be found and corrected, but when this is not possible a biguanide will reduce the insulin requirement and also the tendency to hypo-

glycaemia—for in their own right the biguanides do not produce abnormally low levels of blood sugar in man.

DR. PETRIE: This patient will continue on a 1,200 Calorie diet and continue to see the dietitian. She will now begin metformin, which we prefer because it does not seem to predispose to lactic acidosis. The initial dose will be 500 mg twice daily. She will be followed up at the diabetic clinic.

STUDENT: Does primary or secondary failure occur with metformin and phenformin?

DR. STOWERS: Yes, in which case the addition of a sulphonylurea may then establish good control of the diabetes.

References

- ¹ University Group Diabetes Program, *Diabetes*, 1970, **19**, Suppl. 2, 747; *Journal of the American Medical Association*, 1971, **217**, 777.
- ² *Diabetes*, 1970, **19**, Suppl. 2, p. viii.

Second Opinion, Please

Cancer of the Bowel

A. J. M. CAVENAGH, R. F. RINTOUL

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I suspect that morale at St. Elsewhere's is sustained largely by tea and coffee, which have the virtue of making doctors stop, meet, and talk. A few minutes with the right person and "Mrs. Brown" is worth several formal postgraduate sessions, though it is sometimes hard to persuade nursing colleagues that it is not simply a pleasant waste of time. The late Evan Jones, one of the most inspired Thomas's physicians, sharpened his wits—and everybody else's—consistently in this way. In Holland the "coffee room" is an important part of the hospital architecture and perhaps it deserves a more honoured place over here. Somewhat typically it was a practice discussion over coffee which decided the topic for this article, and Mr. Forbes Rintoul, our visiting consultant surgeon, thought it would be a good idea to present it in the same fashion.

Four Cautionary Tales

DR. CAVENAGH: The general practitioner is said to have an advantage over his hospital colleague in "knowing his patient", but the trouble with general practice is that you see very little of most of your patients, and hardly know them at all, whereas the regular attenders are in serious danger from familiarity breeding contempt. So here are four humiliating cautionary tales which I have collected with the help of my partners. I must emphasize that most of the gaffes revealed are my own.

Brecon

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Mr. A. B. I knew as a competent executive civil servant aged 50, who made light of his war wounds, for which he had to attend on average six times a year. Occasional attacks of gout responded to colchicine, which was thought to have caused diarrhoea on two occasions. Three years ago he had a short-lasting attack of severe abdominal pain, in which abdominal examination was negative and rectal examination was not performed. Five months later he had a similar attack of pain, severe enough to keep him awake all night but with no bowel symptoms. Out of pure serendipity a rectal examination was performed at that time, which showed a small ulcer high posteriorly; on sigmoidoscopy and biopsy this proved to be an adenocarcinoma of the rectum. After abdominoperineal excision he has done well.

Mrs. C. D., aged 45, was over-anxious from the start. I had to enter into correspondence to check the operative findings of a laparotomy for alleged malignant disease shortly after she arrived. (This proved to have been a false alarm; she had had a hysterectomy and appendicectomy for irregular uterine bleeding.) She attended with occasional dyspepsia, epigastric tenderness, and diarrhoea and vomiting over a space of two years. A year ago she gave a history of bleeding piles. Rectal examination at that time was negative apart from the presence of minimal haemorrhoids. Her haemoglobin at that time was 100%. She continued to complain and a further examination a month later was normal; sigmoidoscopy at that time was impossible beyond 15 cm on account of profuse faeces, but these seemed normal in type. Two months later she complained of some irregular bowel habit and low backache. An x-ray film of her lumbar spine at that time was normal. Four months later she reappeared with a history of further irregular bowel action. A barium enema then showed a probable carcinoma at the rectosigmoid junction and a repeat sigmoidoscopy and biopsy revealed a papilliferous adenocarcinoma. At operation it was possible to perform an anterior resection of the growth but she developed fibrinolysis in the postoperative period and had a somewhat tumultuous recovery (as you know well.)

Mr. E. F. was a self-reliant farmer with a smallholding, who had attended the surgery ten times in seventeen years. At the age of 46 he reported with a two-week history of abdominal pain, diarrhoea, and flatulence. On examination he was tender over the sigmoid colon; rectal examination was normal, as was his urine.

He was treated symptomatically and a week later had improved. Nine months later he appeared with bronchitis, his chest x-ray film being normal. A month later he had a sudden painless haematuria and an I.V.P. showed a constant filling defect in the left side of the bladder. Subsequent cystoscopy showed a small tumour projecting into the bladder on the summit of a mass which proved to be an adenocarcinoma arising from the bowel. The liver was enlarged 3 in (7.5 cm) below the costal margin and this was considered an inoperable growth. He progressed steadily downhill and died five months later.

Mr. G. H., aged 63, was a hardy perennial who attended the surgery on an average of 20 times a year over a space of 20 years. Most of his visits were for cervical spondylosis and abdominal pain which was invariably "agonizing". He had had three barium meals in all, and carcinoma of the colon was not suspected until two years ago, when, however, a barium enema and sigmoidoscopy were normal. Six months ago he was admitted to the district hospital with abdominal pain, but apart from a loaded colon no positive findings were made; rectal examination at that time was normal. Two months later he was finally re-admitted and a diagnostic laparotomy was performed, at which an inoperable carcinoma of the sigmoid colon was discovered.

This is a pretty dispiriting collection. In a small town and rural area we have a dual relationship with many patients, who may be friends or may supply us with the necessities of life ranging from milk, papers, or groceries to emptying the dustbins. We live at close quarters with our failures—or their memory—and any advice you can give us on the earlier diagnosis of what seems to be an increasingly common tumour will be most welcome.

Surgical Comment

MR. RINTOUL: The topic which we are discussing covers, I feel, a much wider field than the early diagnosis of colonic tumours in general practice. Hospital methods of diagnosis are by no means infallible but I agree that the chances of missing a tumour are lessened by a second opinion or even a third, when the radiologist's help is requested. I suspect that most of your patients did not, in fact, have a tumour present at your early examinations. The fact that their tumours started to grow during your contact with them—either medical or social—can hardly be blamed on your presence. One important point which I have noted in your case histories is that

you certainly took all reasonable steps to reach a diagnosis at an early stage. I am afraid that I still see patients who have not been subjected to the supposed indignity of a rectal examination and are referred to hospital with large rectal tumours. In my opinion, this is worse practice than to miss a growth during a well-intentioned P.R.

It seems to me that the main problem which faces your management of these patients is *when* a second opinion should be sought. It is a fairly easy decision for me to request a barium enema when other means do not clearly establish the diagnosis, and, indeed, it would be considered negligent, in most cases referred to hospital, not to do so. Unfortunately, it would not really solve the whole problem to refer all your patients with diarrhoea to my clinic.

It would be ideal if a blood test were available as a means of finding out those patients with an early tumour. There are reports of a serological test being developed which, it is hoped, will indicate the presence of a colonic cancer but it may be several years before we have this as a routine test. The E.S.R. is too non-specific to have been helpful in your four patients but I wonder if an unsuspected anaemia would have tipped the balance in your asking for a second opinion at an earlier stage. Not all colon tumours produce anaemia, but the majority will produce occult blood in the stools. The test for faecal occult blood is quite simple when using the highly sensitive Ham's reagent along with hydrogen peroxide, and I have the two solutions available in my outpatients clinic. The test itself takes less than a minute and a sample of faeces can usually be obtained by rectal examination.

I am glad to have another pretext for bringing the subject of the rectal examination into our discussion again because of its great importance, but in the present company I should not really preach to the converted.

Glossary

I.V.P.	Intravenous pyelogram.
P.R.	Per rectum examination.
E.S.R.	Erythrocyte sedimentation rate.

Medical Education

Southampton—Some First-year Experiences

The initial cohort of students at the new medical school at the University of Southampton has just finished the first year's course. Last month, in an interview with a member of the editorial staff of the B.M.J., the dean of the school, Professor Donald Acheson, described some of the lessons of the first year and his plans for the future. He began by discussing problems of student selection.

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PROFESSOR DONALD ACHESON: Most of our students come straight from school. But out of the 40 there are eight who have got a degree in something already.

INTERVIEWER: Was this kind of selection your deliberate choice?

PROFESSOR ACHESON: Partly. We thought it would have a

settling effect on a group which would inevitably be under a lot of stress. There must be now a well-defined "first-cohort-in-the-new-medical-schools" syndrome, and one of the things we've learnt this year is that, even allowing for it in advance, we still underestimated it. It needs a real effort of imagination to put oneself in the position of these students. Some of them feel—though they came knowing they were the first group—that they are being experimented on. Every lecture, every class, every test, every examination is a step into the unknown. They haven't got a senior group of students to whom they can turn and ask what