County, Denmark, blood samples were drawn in the fasting state at 8 a.m. for determination of serum levels of calcium, protein, cholesterol, and triglyceride. The serum calcium levels were corrected to a constant serum protein level.² All determinations were made in duplicate, and the coefficients of variation (C.V.) of duplicate measurements and the mean values and standard deviations (S.D.) are given in the table. A highly significant inverse correlation was found between serum calcium and serum triglyceride ($r = -0.36$, $P < 0.001$). No significant correlation was found between serum calcium and serum cholesterol ($r = 0.03$, $P > 0.05$).

Serum Levels	No. of Subjects	Mean	S.D.	C.V. (from duplicate measurements)
Calcium (mmol/l)	80	2.46	0.06	0.8%
Cholesterol (mmol/l)	80	7.04	1.48	1.5%
Triglyceride (mmol/l)	80	1.27	0.95	2.6%

Conversion: SI to Traditional Units—Calcium: 1 mmol/l $\approx$ 4 mg/100 ml. Cholesterol: 1 mmol/l $\approx$ 38.6 mg/100 ml. Triglyceride: 1 mmol/l $\approx$ 88.5 mg/100 ml.

Our results seem to be supported by the findings that serum cholesterol is lower than normal in patients with hyperparathyroidism and that the serum concentration of lipids increases after operation.³ They indicate that in the elderly serum calcium levels in the lower part of the normal range are not protective against raised serum lipid levels.—We are, etc.,

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¹ Hodkinson, H. M., et al., *Lancet*, 1973, 1, 910.

² Christiansen, C., et al., *Clinica Chimica Acta*, in press.

³ De Moor, P., et al., *Annales D'Endocrinologie*, 1973, 34, 616.

Postoperative Pseudomembranous Colitis

SIR,—We have recently completed a prospective randomized clinical trial to evaluate the effect of systemic prophylactic lincomycin on postoperative sepsis after bowel surgery¹; no other antibiotic was administered. No case of pseudomembranous colitis occurred among the 33 patients who received lincomycin for five days, though the complication was carefully sought. Prophylaxis reduced the incidence of anaerobic but not aerobic infection.

Since this trial we have been combining systemic lincomycin with another broad-spectrum antibiotic and had begun a prospective assessment on patients undergoing elective or emergency resection for large-bowel cancer. Of the 18 patients so far treated, six have developed postoperative pseudomembranous colitis and one has died as a result. In each case the amount of lincomycin received was small (between three and nine 600-mg doses at eight-hour intervals given by intramuscular injection). All six patients received additional broad-spectrum antibiotics (two received gentamicin, three tobramycin, and one co-trimoxazole). No

patient had concurrent disease or debility and hypotension was not observed at any stage during anaesthesia.

The association of lincomycin and pseudomembranous colitis is well recognized, but the pathogenesis of the condition is not understood and is probably multifactorial.^{2,3} Several points arise from our recent experience: firstly, small doses of lincomycin do not prevent the complication of colitis; secondly, the combination of lincomycin with a broad-spectrum antibiotic such as an aminoglycoside may increase the incidence of colitis; and finally, our present prospective trial of a combination of lincomycin and an aminoglycoside as prophylaxis against postoperative sepsis has been discontinued on ethical grounds.—We are, etc.,

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¹ Keighley, M. R. B., et al. In preparation.

² *British Medical Journal*, 1974, 4, 65.

³ Tedesco, F. J., Barton, R. W., and Alpers, D. H., *Annals of Internal Medicine*, 1974, 81, 429.

Surgery of Violence

SIR,—I have read with interest the articles in your series Surgery of Violence. Our recent experience in Cyprus underlines many of the excellent points made in these articles.

On 15 July 1974 a coup was staged in Nicosia and this was followed by an invasion by Turkish troops on 20 July and a subsequent "push" by these troops to Famagusta on 14 August. The British Military Hospital at Dhekelia received wounded of both Cypriot communities and of the contingents serving with the United Nations Force. In all, 59 patients were admitted with injuries associated with this violence. The sites of wounding were: upper limbs, 16 (three with fracture); lower limbs, 32 (six with fracture); head, four; neck, one; chest, seven; abdomen, eight; multiple fragments, two. (Some patients had more than one wound.)

The wounds were caused by mine, shell or bomb fragments, high and low-velocity bullets, and (in one instance) a bayonet thrust. Treatment followed standard military lines which lay emphasis on the following points. (1) Adequate intravenous resuscitation with fluids and blood. (2) Exploration and rigorous debridement of all but the most superficial of wounds. (3) All wounds of muscle left open for delayed primary suture in five to six days. (4) Compound fractures subjected to manipulation at the time of debridement, held in padded plaster casts, and internally fixed only if required after sound soft-tissue healing (in none of our cases was this required). (5) Damaged colonic segments exteriorized and formed into a double-barrelled colostomy for later closure. We found the prophylactic use of dexamethasone and hyperventilation¹ extremely effective in the management of our head wounds.

Cases of interest included the following. (1) Temporal fracture and subdural haematoma due to a "side-swipe" by a high-velocity missile. (2) Tear of the internal carotid artery just below its entry into the base of the skull. (3) Bilateral division of the sciatic nerves by a high-velocity missile passing through both hamstring compartments. (4) Damage to diaphragm, liver, hepatic

flexure of colon, and right kidney due to tiny metallic fragment entering right chest. (5) Severely comminuted fracture of femur with tear of the femoral vein caused by an accidental discharge when a soldier dropped his machine-gun.

There was one death in hospital—a young woman with a severe high-velocity missile head injury—and one death of a man of 70 on return to his village following severe wounds of the pelvis and arm.

Violence, as your series suggests, is "coming home to roost" and it behoves all surgeons and casualty officers to be ready to deal with the multiple injuries that ensue, keeping in mind the basic principles which have saved, and will continue to save, many lives.—I am, etc.,

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¹ Crockard, H. A., *Annals of the Royal College of Surgeons of England*, 1974, 55, 111.

Lactase Activities in the Irritable Colon Syndrome

SIR,—In your leading article on lactose malabsorption (17 May, p. 351) the relevance of hypolactasia to the irritable colon syndrome is discussed. The evidence from Oxford¹ and Denmark² is mildly contradictory on this point, though in the latter study jejunal lactase activities were measured in only nine of the 78 patients under review.

We wish to add our own experience in 15 patients (four male, 11 female) diagnosed as suffering from the irritable colon syndrome by previously established criteria.³ The patients were all Caucasians living in this region. Mucosal lactase activities were measured⁴ using whole specimens taken with a hydraulic biopsy instrument. Our control range was established by reference to recent measurements in 32 subjects with histologically normal mucosa.

The mean jejunal lactase activity in the patients was 3.6 IU/g tissue (wet weight), the actual results ranging from 1.6 to 5.8 IU/g. This compared with the control range of 1.9–10.1 IU/g (mean $\pm$ 2 S.D. obtained by log transformation). In only one case was the value below the control range. Our findings support the conclusions of Pena and Truelove¹ that in most cases a cause other than hypolactasia is responsible for the symptoms of the irritable colon syndrome.—We are, etc.,

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¹ Pena, A. S., and Truelove, S. C., *Scandinavian Journal of Gastroenterology*, 1972, 7, 433.

² Gudmand-Hoyer, E., Riis, P., and Wulff, H. R., *Scandinavian Journal of Gastroenterology*, 1973, 8, 273.

³ Chaudhary, N. A., and Truelove, S. C., *Quarterly Journal of Medicine*, 1962, 31, 307.

⁴ Dahlqvist, A., *Analytical Biochemistry*, 1964, 7, 18.

Treatment of Asthmatic Children with Steroids

SIR,—I read with interest and some concern your leading article on this subject (22 February, p. 413). The article correctly