average hospital stay of 10-15 days. Even after the most benign and trouble-free convalescence there remains an ugly, sometimes keloidal, vertical chest scar in young girls and women. This is to be contrasted with a suprasternal incision pain-free post-operatively, a hospital stay of 3-4 days, and an acceptable small thyroidectomy-like scar. In addition the continuing controversy over the timing and dosage of postoperative anticholinesterase drugs is largely eliminated. As soon as spontaneous breathing returns, which it does in a matter of hours because of absence of pain and chest wall disruption, medication is resumed on the identical time and dose schedule as preoperatively. These advantages have been more than borne out in over 200 transcervical operations done in the past eight years.

Furthermore, in our experience one of the main justifications for early thymectomy is based on the ease of the transcervical operation, with its completeness of thymectomy and virtual abolition of morbidity and mortality.—I am, etc.,

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Metastatic Carcinoma Causing Haematemesis

SIR,—On reporting perhaps the first case of haematemesis due to metastatic carcinoma in the stomach, Dr. R. Edwards and Mr. G. Royle (14 June, p. 598), state that "the case demonstrates the necessity for a routine chest radiograph in all cases of haematemesis" apparently because the primary was in the chest. If this is the first reported case, one might guess that this condition occurs once in 100 000-1m. cases of haematemesis. A chest radiograph costs about \$35 in Los Angeles. Accordingly the "marginal cost"¹ of detecting a case of lung carcinoma metastatic to the stomach presenting as haematemesis is \$3½m. to \$35m. (Problems of sensitivity, specificity, and the value to the patient of diagnosis of this lesion have been ignored in this calculation.)

There may well be good reasons for routine chest radiography in haematemesis, but diagnosis of gastric metastasis of lung carcinoma is not one of them.—I am, etc.,

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¹ Neuhauser, D., and Lewicki, A. M., *New England Journal of Medicine*, 1975, 293, 226.

Services Available for Total Joint Replacement

SIR,—I read with interest the article by Dr. J. R. W. Morris (2 August, p. 290) in which he says that the average time in hospital for a total hip replacement was 29 days.

He did not give much prominence to those units which are able to achieve a far higher turnover than this. If the time in hospital could be cut to one-third of 29 days this would treble the number of beds available for arthroplasties. I believe a hospital is not the place to keep an old person after arthroplasty for any longer than absolutely necessary, and often this can be less than a week. Some form of sheltered accommodation may be necessary for a short while

thereafter, but it certainly need not be in an acute ward.

In 1974 the average length of stay for a total hip replacement in this hospital was 13 days, and this has been reduced to 10 days over the past year. By careful management and planned progress I am sure this figure can be lowered further. We have to do this because there are only two orthopaedic wards in this small district general hospital, which are in no way buffered; all accident patients have to be admitted to the same wards.

This approach, shortening the stay in hospital, makes the figures produced by Mr. Morris greatly overpessimistic.—I am, etc.,

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Antibiotics in Surgical Wound Infections

SIR,—Your leading article "Antibiotics in Surgery" (5 July, p. 3) suggests that, in general, there is no rational basis for the use of antibiotics in surgery. However, it would seem that when a surgeon wishes to start antibiotic treatment of a clinically infected wound before bacteriological results are available the "best-guess" antibiotic should be based on recent experience in that surgeon's own hospital both of the organisms most frequently isolated from various types of wound and of the antibiotic sensitivity patterns of these organisms. We have attempted to provide such information for the surgical staff of a local general hospital on the basis of a survey of wound infections there during the year 1974-5. In accordance with a previous report¹ we classified wounds in four groups: clean, clean-contaminated, contaminated, and dirty.

Of the 110 wounds investigated 90 (82%) yielded bacterial growth. The three commonest organisms isolated were: *Escherichia coli* from 38%, *Staphylococcus aureus* from 28%, and *Bacteroides spp.* from 9%. *Staph. aureus* was most frequently associated with clean wounds (19 of 42) and *E. coli* with clean-contaminated wounds (18 of 32) and dirty wounds (14 of 27); the nine contaminated wounds were too small in number for analysis. These findings suggested that clean wounds were most likely to undergo exogenous infection—for example, with *Staph. aureus*—whereas clean-contaminated or dirty wounds were generally endogenous infections—for example, with *E. coli*.

Antibiotic sensitivity results as assessed by disc-diffusion procedures showed that only seven (23%) of the 31 *Staph. aureus* strains were sensitive to penicillin, but all were sensitive to flucloxacillin. Multiple resistance to penicillin, tetracycline, and streptomycin was found in 11 (35%) of the *Staph. aureus* strains, only two of these 11 having the same phage type (85/90W). For the 41 *E. coli* strains the percentage sensitivity against each of the three "first-line" antibiotics was 81% for tetracycline and 73% for both ampicillin and co-trimoxazole, sensitivity to co-trimoxazole being assessed as advised.²

The results of this study indicate that at present, in our area, the "best guess" for treatment of wound infections before the results of sensitivity tests are known would be flucloxacillin for clean wounds; for clean-contaminated and dirty wounds co-

trimoxazole or ampicillin would be preferable to tetracycline since the last is only bacteriostatic and also has a higher risk of toxic side effects. During this study sensitivity tests were not done routinely against "second-line" antibiotics. However, for severely ill patients the "best-guess" antibiotic would generally be gentamicin or tobramycin, though control of therapy involves serum assays. For severe infections following abdominal surgery metronidazole or one of the lincomycins might also be indicated if an infection with *Bacteroides spp.* is suspected.

We wish to thank the consultant surgeons at Kilmarnock Infirmary, Mr. P. D. Livingstone, Mr. J. D. McCardel, Mr. G. J. Ralston, and Mr. J. H. Simpson, for access to their records.

—We are, etc.,

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¹ Report of Committee on Trauma, United States National Academy of Sciences, *Annals of Surgery*, 1964, 160, Suppl., p. 23.

² Garrod, L. P., Lambert, H. P., and O'Grady, F., *Antibiotic and Chemotherapy*, 4th edn., p. 504. London, Churchill Livingstone, 1973.

Pavane pour une Langue Défunte

SIR,—May I, as a professional English technical translator, respond to Professor Philippe Meyer's "Plaint from Paris" (7 June, p. 553) with my own "Lamentation on the Death of the English Language"?

I sympathize with Professor Meyer's predicament and know from my own experience that many Frenchmen share his feelings about the rape of *cette belle langue* at the hands of callous, casual English. But I would ask him to consider how much more traumatic rape must be when perpetrated unwittingly by the would-be lover. For this, in my opinion, is what is happening to the English language as it suffers the daily attentions of French, Japanese, German, etc., not to mention American, authors who must publish or give their papers in English if their work is to make any mark at all. Unfortunately the results are often only barely comprehensible to the native speaker of standard English. If the present trend continues Professor Meyer will require a course in "international sciences" rather than in English (if the two are not by then identical).

I see no feasible cure for the malady. To render the international scientific community bilingual (mother tongue and English) is quite impracticable. The average non-English-speaking scientist will do well to achieve a sound passive knowledge of English plus, perhaps, the basics of oral expression (reasonable pronunciation, simple sentence structure, common verb tenses). The provision of more extensive translation facilities (written and simultaneous) might be a long-term solution, but it would require a massive educational effort to train sufficient translators and interpreters in the requisite linguistic and scientific skills. And governments would presumably not be too forthcoming with financial support since the problem is not really a "national" one.

Perhaps the solution lies after all in an international language of science (but one less "tainted" with overclose association with