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.,

MICHAEL DEVAS

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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

English, please). It would then be up to Professor Meyer and his fellow non-Anglo-Saxons to assert themselves and their respective languages in a new "melting pot."—I am, etc.,

S. C. COOPER

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Overseas Doctors

SIR,—I agree with Dr. R. J. Henderson (26 July, p. 229) when he says, "How could a three-month habilitation course, especially for someone whose English is weak, make up for the deficiencies of several years in an inferior medical school?" Better facilities should be provided in Britain for training overseas doctors. Indian doctors do come to Britain out of altruism because they have a great respect for things British. If they had money on their mind they would have gone to oil-rich countries and to America. They come to Britain for postgraduate training instead of going to America, in spite of the fact that many British graduates receive postgraduate training in America. The image of Britain as a centre for postgraduate studies in medicine has been eroded. As a result overseas doctors in this country are drifting fast to America for postgraduate training.

There is no denying the fact that a strong emotional reaction against immigrants, once confined to shop floors, is now affecting the medical profession. This trend has been perceptibly growing over the past decade and has now come to a head. Cheap labour was welcome in the factories only during the depression of the 1930s. So was cheap medical labour welcome when the N.H.S. badly needed overseas doctors. The General Medical Council has shown a lack of sensitivity in dealing with the issue. The human element has been missing. The G.M.C. knows as well as anyone else that spoken English can be picked up only by being in this country. The English themselves have difficulty in learning the dialects of Scotland. Overseas doctors should be accepted for training on a basis of equality. In America after passing the E.C.F.M.G. one is accepted for training on an equal footing with an American for internship and residency. But for training in Britain there are no assurances and no safeguards.

When an overseas doctor in this country does not come up to expectation it tends to hit the headlines and the response of the mass media verges on hysteria. The B.M.A. should have intervened before as well as at the present juncture. It should have suggested that discussions on examinations for overseas doctors and their results should be held behind the scenes.—I am, etc.,

NESAR AHMED

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Primary Care and the Elderly

SIR,—The *B.M.J.* is to be congratulated on giving reasonably good coverage of the recent Annual Representative Meeting at Leeds and also of the Annual Scientific Meeting (26 July, p. 221).

I think, however, that it is regrettable that in the account of the symposium on Primary Care and the Elderly no comment was made on the important discussion

following a question I myself put to the panel concerning hearing aids and the elderly. This was accepted by the expert panel as of extreme importance. In addition, questions about the precise role of calcium supplements in both the skeletal system and maybe in the C.N.S. were rather summarily dismissed. Also, because of lack of time, a further question asking for the opinion of the panel on the acrimonious issue of euthanasia was conveniently dismissed, though at a time when there are so many experts clearly doing their utmost to further the care of the elderly there are yet other influential ones who support euthanasia. The B.M.A., quite rightly in my opinion, has stated its view that euthanasia is to be condemned.¹

The wider use of hearing aids would certainly help many of the elderly who find a progressive loss of hearing adding to a feeling of social isolation already present because of physical infirmities. Unfortunately attitudes to the physically disabled, aged or otherwise infirm, are to say the least very laissez-faire. No wonder some imagine that some of their fellow human beings would be better out of this world! A little more thought and kindness might rectify this despicable attitude to the less privileged members of society.—I am, etc.,

MABEL LOIS HAIGH

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¹ *British Medical Journal Supplement*, 1969, 3, 66.

Control of Transient Cerebral Ischaemic Attacks by Heparin

SIR,—We report the case of a patient with transient cerebral ischaemic attacks which did not respond to oral anticoagulants, but appeared to be effectively controlled by small doses of heparin given subcutaneously.

The patient, a previously healthy man aged 59, awoke in the night feeling unwell and unable to move his left arm. On arrival at hospital two hours later his disability had recovered completely. Next day, however, he began to have repeated attacks of a burning sensation around the nose and lips, slurred speech, and left-sided weakness. Subsequently the episodes of hemiparesis alternated between left and right. His blood pressure was 150/80 mm Hg in both arms, all pulses were readily palpable, and no arterial bruits were heard. During attacks he exhibited dysarthria, nystagmus, and pyramidal signs in the limbs with sensory impairment, sometimes on the right and sometimes on the left. He remained conscious and lucid throughout though he was incontinent on occasions. Transient ischaemic attacks in vertebrobasilar territory were diagnosed. His blood count, blood urea nitrogen, blood sugar, cholesterol, lipid profile, and tests for syphilis were satisfactory, as were radiographs of chest and skull. An E.C.G. showed a partial bundle-branch block attributed to ischaemia. A continuous heparin infusion (10 000 U in 6 h) was given on the third day in hospital and the ischaemic attacks ceased within hours. At the same time warfarin by mouth was given. After 48 h the heparin infusion was discontinued, but two days later the ischaemic attacks began again despite more than adequate oral anticoagulation (British Ratio 5.2). Attacks recurred with increasing frequency over the next five days, when heparin was reintroduced by the subcutaneous route in a dosage of 5000 U every 12 h using a solution containing 25 000 U/ml. There were two further slight ischaemic attacks 48 h later, which then ceased. The injections were continued after discharge from hospital. Warfarin was withdrawn after a month without ill effect and the patient continued the heparin regimen for 10

weeks without complications. Two weeks after heparin was withdrawn the patient had one further attack and is currently taking aspirin and dipyridamol.

Several studies point to the usefulness of small doses of heparin given subcutaneously in preventing venous thrombosis after surgery. The precise way in which the low circulating levels of heparin act is not yet clear, but recent experimental work suggests this may be through enhancing the natural inhibitory property of plasma against thrombin and activated factor X.^{1,2} Theoretically the formation of thrombi within the arterial system may be less susceptible to influence by heparin, which can enhance the adhesion of platelets to collagen and their aggregation one to another. On the other hand, inhibition of the platelet release reaction by heparin may be more important in preventing subsequent embolization, and it is in this context that our observations are of interest. If confirmed they could provide a method of management in a clinical situation unresponsive to conventional therapy and fraught with the risk of a major stroke.—We are, etc.,

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¹ Han, P., and Ardlie, N. G., *British Journal of Haematology*, 1974, 27, 253.

² Yin, E. T., Wessler, S., and Stoll, P., *Journal of Biological Chemistry*, 1971, 246, 3694, 3703, 3712.

Excessive Use of Psychiatric Services by Suicidal Patients

SIR,—I was somewhat surprised to find that in their paper (26 July, p. 216) Dr. D. J. Pallis and his co-workers quoted some figures I had reported at a conference in September 1974. In their introduction, when reviewing findings on the frequency of suicide attempts in psychiatric patients, they said: "A more recent survey in Oxford showed that one in every 11 inpatients or day-patients had attempted suicide over a six-month period—a rate of 8800 per 100 000 patient population." I would like to comment on this statement partly for the sake of clarification. My study was a one-year prospective survey of persons carrying out deliberate acts of self-poisoning or self-injury while psychiatric inpatients or day-patients. In the context in which it occurred in Dr. Pallis and his colleagues' paper the statement could have been interpreted as referring to the number of patients found to have a previous history of such behaviour. I would in any case be loath to use the term "attempted suicide" to describe the majority of these acts since many involved, for example, minimal cutting of the skin.

Since the figures quoted referred to the first six months of the study and were provisional I feel I should give the final findings. The overall rate for this behaviour was 3330 per 100 000 patients at risk (or one in every 30), which is considerably less than the figure that was quoted. Of more relevance to Dr. Pallis and his colleagues' study are my findings on scrutinizing the case notes of a consecutive series of 300 psychiatric hospital patients, when I found that at least