Rates of registration of gastric cancer (per 100 000) by sex for 1962-5[3] and 1978-82[4] in Denmark, Finland, Norway, Sweden, West Midlands region, and Scotland, standardised to world standard population (all ages) and to truncated world standard population (ages 35-64 only)

	Men				Women			
	All ages		Truncated		All ages		Truncated	
	1962-5*	1978-82†	1962-5*	1978-82†	1962-5*	1978-82†	1962-5*	1978-82†
Denmark	27·5	14·3	31·0	14·1	16·4	6·7	15·6	7·0
Finland	44·9	24·6	57·6	25·7	23·4	12·9	25·8	13·7
Norway	28·8	18·1	35·3	18·4	15·4	9·2	17·7	9·7
Sweden	24·8	15·0	28·3	13·8	13·0	7·5	15·1	7·7
West Midlands	25·2	20·3	35·9	21·6	13·2	8·4	16·5	8·2
Scotland	21·1	20·4	34·2	23·2	10·3	9·6	14·4	9·1

*Except Denmark (1958-62), Norway (1964-6), and West Midlands and Scotland (1963-6).
†Except Finland (1977-81) and West Midlands (1979-82).

responding rates are included for Scotland and the West Midlands region. An appreciable decline in the incidence in both sexes in each of the Scandinavian countries is shown. On average, the adjusted rates for all ages around 1980 are 56% of those around 1963; if truncated rates are used the figure is 49%. In Scotland the corresponding change in the rates for all ages (used by Mr Sedgwick and colleagues) is smaller than that in Scandinavia or the West Midlands, but in the truncated age range 35-64 the decline is appreciable (down to 65% of the earlier rate). The data do not contradict the general conclusion that gastric cancer is indeed a disease in decline.

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Minimally invasive surgery in sickle cell disease

SIR,—In her editorial Dr Sally C Davies highlighted the problems of patients with sickle cell disease,[1] as did Bannerjee *et al* in a recent leading article elsewhere.[2] Clearly, any surgical procedures carried out on these patients should be accompanied by meticulous attention to the details of fluid balance, control of the ambient temperature, prophylaxis against infection, and anaesthesia.[3,4]

Surgical procedures are not uncommon in sickle cell anaemia—for example, pigment gall stones secondary to chronic haemolysis may be detected in about 36% of these patients under 16 years of age, increasing to over 80% of patients by the age of 40[3]; many of these patients are treated by cholecystectomy.[5] The recent introduction of laparoscopic surgery for gall bladder disease reduces surgical trauma and is associated with a shortened postoperative recovery period.[6] We believe that this is of great benefit to patients with sickle cell disease and have used the technique in a child.

A 12 year old girl with recurrent abdominal pain associated with multiple pigment gall stones had an elective laparoscopic cholecystectomy after preparation with a preoperative transfusion of two units of whole blood. Her haemoglobin concentration at operation was 116 g/l. She was well hydrated with intravenous fluids throughout the procedure. A constant pneumoperitoneum was maintained with a carbon dioxide insufflator (flow of 1-2 l/min). To minimise any possible harmful effects of the consequent respiratory acidosis relative hyperventilation with measurement of end tidal carbon dioxide was used. On the second postoperative day she was fully mobile, eating normally, and fit enough to be discharged home.

We believe that minimally invasive surgery done through a laparoscope can lead to a reduced incidence of complications in patients with sickle cell disease and that it is a satisfactory technique in children.

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Pethidine for painful crises in sickle cell disease

SIR,—We agree with Dr Sally C Davies's statement that pethidine may be detrimental to outcome when used for analgesia in painful sickle cell crises.[1] Recently a 23 year old man admitted with sickle cell crisis died after treatment with a continuous intravenous infusion of pethidine. Having received 100-150 mg of pethidine an hour for two days, the patient developed grand mal seizures and died. At no time was his pain adequately controlled. Although his serum pethidine concentration was 2·2 mg/l (upper limit of the therapeutic range 2 mg/l), his serum norpethidine concentration was 5·2 mg/l at the time of death. This is more than three times the upper limit of the therapeutic range (1·5 mg/l).

If this case is representative we are seriously concerned about the continued use of pethidine in this condition. Pethidine is the least potent of all the clinically used synthetic opioids and has the narrowest therapeutic index of all opioids. Accumulation of norpethidine is a well recognised complication of multiple dosing with pethidine. It is more likely to occur in renal impairment, which may occur when dehydration complicates acute sickle cell crisis. Norpethidine is a major stimulant of the central nervous system that causes convulsions—highly dangerous for a patient with sickle cell disease. In addition, it may be postulated that norpethidine is antagonistic to the effects of pethidine. This may explain the frequent lack of analgesia associated with an increasing dosage of pethidine.

Concentrated research effort must continue to be made to elucidate further the pathophysiology of painful sickle cell crises, thereby ensuring an improvement in therapeutic intervention.

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Puncture the skin before inserting a needle

SIR,—Minerva mentions a case report that highlights the danger of epithelial tissue being implanted in the spinal theca when lumbar punctures are performed with unstiletted needles.[1]

We think that it should be routine practice to puncture the locally anaesthetised skin with the sharp tip of a small surgical blade before inserting an epidural or spinal needle. Besides avoiding dermal tissue being torn and carried on the tip of the needle this technique allows the operator to introduce the needle in the interspinous space with less force and hence with more control over its initial trajectory, thus enhancing safety. We also recommend puncturing the skin before inserting a needle percutaneously for other procedures—for example, central venous catheterisation. The lumen of the needle is less likely to get blocked, and threading a dilator (when indicated) and the catheter is made easier.

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1 Minerva. Views. *BMJ* 1991;**302**:1550. (22 June.)

Your child is dead

SIR,—Dr Ilora Finlay and Ms Doris Dallimore wrote on how deaths of children are handled,[1] but as well as the immediate needs of the bereaved parents, the way siblings are informed of death is important. Children are often relatively ignored in bereavement, which forces them to suppress their emotional needs.

I have been treating patients with anorexia nervosa by regression under hypnosis, with some success. Numbers are still small and therefore my data are only anecdotal, but many of the girls when aged about 9 had suffered a bereavement, usually the death of a grandfather. Importantly, I have found that the grieving process was not allowed to follow its natural course and that the child had not been able to mourn.

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1 Finlay I, Dallimore D. Your child is dead. *BMJ* 1991;302: 1524-5. (22 June.)

Antepartum haemorrhage and cervical cancer

SIR,—We take issue with Professor Geoffrey Chamberlain over his description of the character-

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