SIR,—Dr. P. W. Hutton writes (7 December, p. 643): "The N.H.S. in common with other British industries attracts labour to do work its own native people are not prepared to do." So long as an immigrant is filling an establishment in some half-crippled geriatric or mental hospital it is possible to pretend that he is here to further his medical education, however unsuitable he may be for the job and however unlikely it is that he will get any education. When he becomes a principal in general practice the fiction has to be abandoned. People do not go into general practice to get educated but to scratch a living.

The Essex medical list for 1965 contained the names of 131 doctors, principals giving unrestricted service, who had joined the list since 1961. Of these 101 (77.6%) were graduates of English or Scottish universities, 4 (3.1%) graduates of Irish universities, and 1 (0.8%) was a graduate of an Asian university. The 1968 list showed 137 newcomers, of whom 75 (55.7%) were English or Scottish graduates, 14 (10%) were Irish graduates, and 18 (16.8%) had Indian or Middle-Eastern qualifications. Further to decipher the writing on the wall, 87 (66.9%) of the 1961-5 recruits had been qualified less than 10 years, while in 1965-8 the number was only 56 (40.9%).—I am, etc.,

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Surgery for Perforated Duodenal Ulcer

SIR,—Mr. M. G. Machayya (19 October, p. 155), at present on leave in India, may find it difficult to reply to the correspondence of Mr. R. M. Kirk (2 November, p. 327), and Mr. Peter F. Jones and Mr. Terence Kennedy (16 November, p. 450) relating to his article on the immediate treatment of perforated peptic ulcer by vagotomy and pyloroplasty. As all the patients mentioned were so treated at our instigation and under our care we would like to comment on some of the points raised.

These letters suggest that Mr. Machayya over-estimates the number of patients who will require further surgery if their perforations are treated by simple closure. Mr. Machayya cites Mr. J. A. Shepherd (9 March, p. 625) in suggesting that only 25% will remain symptom free and draws the inference that most of the remaining 75% will have further surgery. Mr. Kirk deprecates the immediate radical operation on the basis that it is done only to protect 25% from further surgery within 5 years; this would seem to interpret Mr. Shepherd's findings as meaning that he recommended surgery for only a third of the patients with persistent and recurrent trouble from their duodenal ulcer after simple closure of perforation. Mr. Shepherd's article does suggest that there is a place for emergency vagotomy on the basis of the chronicity of the ulcer, but acknowledges the difficulty in defining the acute from chronic, both on the basis of histology and appearance.

Seeking a further yardstick, we looked up the records of the 40 previous consecutive perforations which had been treated by simple closure. We took it that if they had not reported to the hospital or to their general practitioners with further dyspeptic symptoms that they had remained symptom free as far as the duodenal ulcer was concerned for the

six years plus. All but one were traced and he was included as "symptom free." The findings are as follows:

Further symptoms and surgery ...	23
Further symptoms without surgery	12
No further symptoms ...	5
	40

Further surgery was carried out at an average of 3.5 years after perforation. Two of these operations were for further perforation from which one patient died. Of the 12 who did not have further surgery one died from pyloric stenosis and another from duodenal haemorrhage. The notes record that in several of these cases further surgery was advised but declined. Taking into consideration the morbidity of those having further operation, the continuing symptoms of those without, and the three deaths from further complications the pattern in our practice, we consider, bears out Mr. Machayya's contention that "a radical curative procedure at the time of dealing with the ulcer would, therefore, seem indicated. . . ." In his paper Mr. Machayya does not indicate whether he would recommend any basis for choosing simple closure, though it might be argued that he makes a case for exclusion from the radical procedure of the late perforation in the very old.

Mr. Jones describes a trial he carried out in which 16 of 34 patients had a Polya gastrectomy at the time of perforation. Cases were those considered to have a chronic ulcer, the other 18 judged to have acute ulcers had simple suture. But of these 18 patients 3 had further surgery for duodenal ulcer within a four-year follow-up period. In one sense our figures corroborated those of Mr. Jones in that the five remaining symptom free after simple closure gave no previous history of digestive trouble, as one would anticipate. However, there were five other cases with no previous history of dyspeptic trouble, but of these only two did not have further surgery though continuing to have symptoms. Thus attempting to select our cases on Mr. Jones's basis would have meant offering immediate radical surgery to 75% of cases and later recommending the operation for a further 7.5%, possibly 12.5%.

We consider that the operative morbidity and mortality figures confirm the competence of our registrars to do these operations.—We are, etc.,

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ARTHUR W. B. STRACHAN.

North Lonsdale Hospital,
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Draining Loop Colostomy

SIR,—The standard L-shaped glass Paul's tube has certain disadvantages when used for draining a loop transverse colostomy. The principal disadvantage is the need for bulky dressings to prevent it falling over sideways under the weight of the bedclothes. Also it is inclined to fall out, and if tied in with a length of glass tube inside sufficient to prevent dislodgement it may also prevent adequate drainage. Obviously there is a place for an improved design, but until this is available the simple device illustrated can be improvised.

A 50 ml. disposable plastic syringe such as is used for bladder washouts has the barrel sawn off 1 cm. from the end, and the narrow distal

part of the nozzle is sawn off as well. The colostomy is opened in the usual way with a cruciate incision of about 1.5 cm. each way, and the wide part of the device manoeuvred inside. It will stay in position satisfactorily without any fixation, but a loose purse string suture inserted round the cut margin of the colostomy makes it more secure. A rubber tube is attached to the nozzle.

Drainage of transverse colostomies by this means has proved to be quite satisfactory, and the device can be removed after four or five days when the faeces are becoming more viscous and the abdominal wounds are less likely to be contaminated. The method would probably be unsatisfactory for use in a pelvic colostomy owing to the more solid faeces excreted.—I am, etc.,

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Pneumomediastinum and Diabetic Hyperpnoea

SIR,—Arising from the memorandum by Professor B. McNicholl and others (23 November, p. 493) may I describe a further case in which this occurred on two separate occasions?

On 19 December 1962 a girl aged 12 years 7 months was admitted with a history of three weeks' intense thirst, frequency, and loss of weight. This had been preceded by a sore throat. She was afebrile, her apex beat was 160 per minute and feeble, and her respirations were deep and 40 per minute. She had pain on the left side of the chest, and there were crepitations at both bases. She was very ill, semi-conscious, and the urine showed heavy glycosuria and ketonuria. The blood sugar was 900 mg./100 ml.

The diabetic coma responded rapidly to treatment, but on the next day she was found to have acute follicular tonsillitis from which grew *Staph. pyogenes*. There were now coarse noises confined to the precordial region, and acute pericarditis was considered possible. Total leucocytes were 18,000 per cu. mm. An x-ray revealed extensive surgical emphysema demarcating the planes within the mediastinum, and passing up to the neck. There was no evidence of a rib or lung lesion.

On 22 December the emphysema was seen on x-ray to have considerably diminished in the mediastinum, but it was then clinically obvious in the neck. From then on she made an uninterrupted recovery, and was discharged to the clinic on only 12 Soluble+6 Prostamine Zinc