disadvantage. Not only does he have to communicate with the patient and often take a clinical history, but unless he can provide an accurate, easily understood report at the end of an examination his time has been wasted.—I am, etc.,

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Surgery on Day Patients

SIR,—Mr. R. T. Burkitt (10 November, p. 360) tells us that he has "been practising 'day case surgery' on selected patients for many years. There have never been any problems, and the only people involved have been the surgeon, the patient, and his general practitioner."

May we conclude that he operates solely under local anaesthesia? If not, then he shows the same disregard for his anaesthetist which is such a lamentable aspect of some surgical thought and practice. His patients may well be "selected," but suitability for day case surgery should be based on anaesthetic as well as surgical considerations.

This is only one of several valid points made in the document H.M. (73)22, and if Mr. Burkitt has not already agreed on appropriate criteria with his anaesthetic colleagues, then the appearance of this memorandum is not merely timely, but long overdue.—I am, etc.,

G. T. WHITFIELD

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Hazard of Petrol Shortage

SIR,—I was interested to read the article by Drs. R. L. Barnes and D. S. Wilkinson on epidermal necrolysis due to paraffin (24 November, p. 466). I would like to report a similar case due to petrol which is relevant to the present fuel crisis.

Last week a patient aged 36 attempted to syphon petrol from a friend's car as she thought she would be unable to obtain a can of petrol from a garage for her car. She sucked intermittently for one hour through a rubber hose pipe inserted into the tank, after which she felt nauseated and drunk. She had not succeeded in drawing up any petrol but had inhaled the vapour. Shortly afterwards she vomited and had one episode of diarrhoea. She also noticed extensive perioral blackening of the skin which peeled off on washing.

When seen in the surgery the following morning she had a well-demarcated perioral erythema in which vesicles appeared later. She thus had had a chemical burn from the petrol vapour. This has settled with bland local treatment. No doubt further cases may be seen in the near future.—I am, etc.,

B. L. ROBINSON

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Effect of Bran on Bowel Function

SIR,—We were most interested to see the paper in which Dr. M. A. Eastwood and his colleagues (17 November, p. 392) report the effects of increased dietary fibre (bran) on

intestinal transit rate. Their results are very similar to those found in our previous study,¹ showing that fibre speeds up transit in subjects whose transit time is initially three days or more, whereas transit rate is unaltered or actually decreased in subjects whose rate is initially fast (transit time < 2 days). The authors of the paper have not done their data justice, however, in saying that "intestinal transit time did not significantly alter." What they mean is that the methods they chose for the statistical analysis (details of which are not given) were unable to demonstrate the statistical significance of their results. If they had analysed the transit-time data shown in their figure in the three ways described in our paper their conclusions would have been different.

Thus in their four subjects whose transit time was initially slow (> 3 days, mean 94.0 hours) bran produced a significant shortening of transit time (mean value after bran 50.0 hours, $t=3.47$ (paired t test), $P<0.025$). Conversely, in those subjects whose initial transit time was relatively short (< 2 days, mean 28.75 hours) bran produced an increase in transit time (mean value after bran 37.0 hours, $t=1.78$, $0.05 < P < 0.10$). A 2-day (44-54 hour) transit time was seen in none of the subjects initially, but was found in six of the eight subjects after bran ($\chi^2=6.0$, $P<0.025$). Of these six, four had started with a slower and two with a faster transit.

The findings of Dr. Eastwood and his colleagues are thus both significant and of great interest in confirming not only what might be expected—that bran speeds up slow transit—but also in supporting the suggestion that in some circumstances bran may actually slow down a fast transit. The implications of this were discussed more fully in our previous paper.¹—We are, etc.,

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¹ Harvey, R. F., Pomare, E. W., and Heaton, K. W., *Lancet*, 1973, **1**, 1278.

SIR,—Dr. M. A. Eastwood and his colleagues (17 November, p. 392) do not state what form of bran was used in their studies. In the past this has, so far as I am aware, always been processed bran, but in 1931 I started experimenting with unprocessed bran and described the results of the use of this material in 1941,¹ in 1962,² in 1966,³ and yet again in 1972.⁴ As the result of my experience, not only in thousands of personnel in H.M. ships at sea, but also when carrying out specialist duties for some 20 years in naval hospitals, I am convinced that unprocessed bran approximately halves the average intestinal transit times occurring with a Westernized diet. This figure was supported by planned provisional studies by Dr. G. D. Campbell and myself^{5,6} on Africans living on unrefined maize and later confirmed in much more comprehensive studies by Burkitt et al.⁷

As regards the slowing down, in some cases, of rapid transit time, I am convinced, again from my own experience, that this is not due to any direct effect of bran on the

intestines, which I have always found to be solely aperient, but to its indirect effect of cutting down to some extent the over-consumption that invariably accompanies a refined Westernized diet and which results in abnormal bacterial activity in the gut and the production of the evil-smelling skatole, indole, and other irritant toxins.⁸ I am naturally very pleased to note the rapid spread of unprocessed bran in this country, including certain hospitals in Reading, Bristol, London, and elsewhere, but I think it would be a pity if this spread, based on its natural aperient powers, led to much of its employment in non-specific diarrhoea without constipation, where I am convinced that the dominant treatment lies in the cutting down of consumption of refined sugar in all its forms, which is a far worse cause of over-consumption and evil-smelling motions than is any lack of bran.⁸—I am, etc.,

T. L. CLEAVE

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- ¹ Cleave, T. L., *British Medical Journal*, 1941, **1**, 461.
- ² Cleave, T. L., *British Medical Journal*, 1962, **1**, 191.
- ³ Cleave, T. L., and Campbell, G. D., *Diabetes, Coronary Thrombosis and the Saccharine Disease*. Bristol, John Wright, 1966.
- ⁴ Cleave, T. L., *British Medical Journal*, 1972, **2**, 408.
- ⁵ Cleave, T. L., and Campbell, G. D., *British Medical Journal*, 1968, **1**, 579.
- ⁶ Campbell, G. D., and Cleave, T. L., *British Medical Journal*, 1968, **3**, 741.
- ⁷ Burkitt, D. P., Walker, A. R. P., and Painter, N. S., *Lancet*, 1972, **2**, 1408.
- ⁸ Cleave, T. L., *Lancet*, 1973, **1**, 1443.

Royal Fleet Auxiliary

SIR,—Many doctors are unaware of the existence of the Royal Fleet Auxiliary and its close association with the Royal Navy. There are some 22 R.F.A. ships carrying doctors, and medical services are well up to date. It may be of interest to doctors approaching retirement from the N.H.S. to know that the above service offers opportunity for sea travel to most parts of the world, with advantages for study, comfortable accommodation, and an abiding interest in medicine.—I am, etc.,

F. R. CORFE

R.F.A. Olwen,
B.F.P.O. Ships

W.M.A. and Racial Discrimination

SIR,—Your leading article (3 November, p. 245) and report of the 27th World Medical Assembly in Munich (*Supplement*, 3 November, p. 23) will probably have misled many of your readers into falsely concluding that the future bodes well for the revitalized World Medical Association. Having attended the whole Assembly, I am sad to report a different story. I believe that in the last two days in Munich the delegates to the Assembly (including those of Great Britain) by their parochialism and political insensitivity successfully destroyed the hopes of transforming this small, European-dominated club into a truly international medical body.

This tragedy occurred as a result of the Assembly's refusal to deal with the specific issues involved in Ghana's resolution on "colour discrimination in medical practice." This resolution merely asked the Assembly to condemn colour discrimination in medical