A Surgeon’s Reflections

It is no disparagement of the extraordinary advances in surgery during the last 50 years to say that blood transfusion and improvements in anaesthesia helped greatly to make them possible. The first used to be a major enterprise, with all the relatives lined up for matching of the blood groups, as Sir Charles Illingworth records in his recently published Rock Carling Fellowship lecture. A beaker, a glass funnel, some rubber tubing, and a few needles were boiled up—and the risk of hepatitis was negligible. In drawing on a professional experience that has covered about that span of time Sir Charles recalls the time when “the operation team was grouped as for a drama.” In the limelight at the converging point of interest was the surgeon, dominant and incisive, while attendants stood around like a Greek chorus. Today he is apt to be almost lost in a crowd of technicians with their complicated equipment monitoring the patient’s vital processes; and the anaesthetist, “no longer much concerned with the simple task of keeping his patient asleep,” is in control of elaborate apparatus to keep him alive.

That surgeons can offer enormously more comfort and relief to humanity than they could 50 years ago is undoubted. But like practitioners in other branches of medicine they are now having to make painful decisions on whether it is really in the patient’s best interest to be treated at all, and if so how. In one way there is nothing new in this, for “inoperable” cases have always been recognized. Now, however, the old jibe that the operation was successful but the patient died is becoming outdated. In its place we see what can be the sadder conclusion that the operation was successful and the patient lived—a life of painful and restricted invalidism. With different overtones this problem faces the surgeon in charge of a baby with a severe defect of the central nervous system, a young adult reduced by a road accident to “a pithed heart-lung preparation,” and an elderly victim of a progressive disease. In such circumstances, says Sir Charles, the humane surgeon watching his patient suffer may be tempted to let the natural process of decay proceed to its appointed end and even to hasten it, while the one who believes that by divine decree the ultimate spark of life must be preserved will take the opposite view. All would agree with Sir Charles that these decisions must remain a matter for the individual conscience. How they are taken for each patient may be what distinguishes the great surgeon from his colleagues.

The preparation of young people for what can be one of the most arduous ways of earning a living still suffers from too much trivial clerking just at a time when they should be devoting themselves to laying a foundation in the craft. Obviously nobody can escape the routine chores that accompany almost any occupation, and the cry sometimes heard to be given more time to work “creatively” is apt to come mainly from people who have little capacity to “create,” for those who have it make the time. But if housemen are engaged on two hours of secretarial duties a day and another hour on taking blood samples for laboratory estimations, as Sir Charles says does happen, they can only have too little time for the real business of learning their profession. And in this respect it is the old-established teaching hospitals, he says, which are the worst offenders. The Goodenough Committee, whose report led to the institution of a pre-registration year, and the Royal Commission, which again emphasized the overriding importance of educational opportunities after graduation, have come and gone and left some sort of a mark in their transit, yet nobody can feel happy that enough is being done to enable professional people, especially the young, to equip themselves for such a swiftly and continually changing occupation as the practice of medicine has become in the last 20 years and will certainly be in the next 20.

Pharmacological Control of Upper Gastrointestinal Bleeding

Acute upper gastrointestinal bleeding is still a common cause of admission to hospital, and during the last 20 years the mortality rate from the condition seems to have fallen little, if at all, hovering obstinately around 10%. Thus an overall mortality of 8-9% was found in a recent review of experience in Oxford, and in comparing the results obtained in three successive quinquennia the only major improvement noted was that fewer men were dying with gastric ulcers. This general lack of improvement is depressing, especially since the proportions of patients with haematemesis and melaena who were over 60 years of age had not risen with time, and it is the elderly who form the bad risk group.

In improving the results of treatment the procedures advocated have been early diagnosis, prompt and adequate blood transfusion, and a more vigorous surgical approach with a trend away from partial gastrectomy and towards vagotomy. Though the need for blood transfusion is obvious, the particular value of early diagnosis is doubtful. It has become a catch phrase that no surgeon welcomes a blind date with a haematemesis, but the increased comfort claimed from, say, a barium meal examination may be more illusory than real in a country where acute and chronic peptic ulceration are much the commonest causes of bleeding. Thus in patients who have clear radiological evidence of duodenal ulcer careful examination of the stomach for a missed gastric ulcer on the posterior wall or an acute erosion will still be necessary. Moreover, in patients with bleeding peptic ulcer the need for surgery is based on the presence of haemorrhage rather than the type of ulcer.

Apart from problems of malnutrition the relatively high mortality associated with partial gastrectomy has been one of the principal sources of dissatisfaction with the procedure and the causes of the turn towards vagotomy. Moreover, partial gastrectomy for gastrointestinal bleeding may be a drastic solution for what may be only a short-term problem, and so it would be natural to prefer an approach which did not interfere permanently with normal gastrointestinal function. One such approach is the attempt to combine diagnosis, by selective angiography, with treatment by infusion into the appropriate vessel of a combination of propranolol and adrenaline. This is similar to the now established treatment of bleeding oesophageal varices by a rapid intravenous infusion of vasopressin, which lowers portal venous pressure by constricting the splanchic arteriolar bed. Experimentally propranolol and adrenaline have previously been shown to be as effective as vasopressin in reducing mesenteric blood flow, and clinically of 11 patients treated for a variety of conditions causing haematemesis and melena one only, with advanced arteriosclerosis and a coagulation defect, failed to respond promptly.

Obviously more work will be needed to establish the value of this treatment, and in theory it would be right to call for a controlled therapeutic trial in which patients who had had a bleeding site demonstrated by angiography would then receive randomly either a control or a vasoconstrictor infusion. Nevertheless, upper gastrointestinal bleeding occurs at inconvenient times, and may start and stop abruptly, and any therapeutic trial would be a formidable undertaking. A better approach to the problem might be to try to develop either vasoconstrictor drugs with a selective action on the gut or an easier approach to selective treatment. Is the time ripe, for instance, to re-examine the value of orally administered vasoconstrictors which might have a direct topical effect on the bleeding lesion?

Postal Strike

For nearly two months the strike of Post Office workers has prevented the normal home and overseas circulation of the B.M.J., and we apologise to readers for this. During this time extra copies of the journal were distributed as widely and strategically as possible—to B.M.A. branches and divisions through the Association’s regional offices, to as many postgraduate centres and teaching hospitals as could be reached through the kind offices of postgraduate deans and regional hospital boards, and to certain key libraries. So far as possible copies were also made available to callers at B.M.A. House. Nevertheless coverage was patchy, especially in outlying areas, and we are most grateful to those who passed on their journals to others. The missing back issues will be sent to all members and subscribers as quickly as the Post Office can handle them. One of the difficulties of this period has been the need to set aside and store 85,000 copies of the B.M.J. each week so that everyone may be sure of eventually getting his copy.

Apart from the interruption of scientific communication occasioned by the strike, advertisers and their clients have also been hit. If the Health Service is to function properly vacant posts must be filled and doctors must know where the vacancies are. To mitigate this hindrance, copies of our classified advertisement pages were supplied to regional boards and so to many hospitals. Drug Houses continued their advertisements despite the strike. We should like to thank all our advertisers for their support during this trying time, and our readers for their patience.

The Forgotten

No matter how comprehensive a country’s medical or social services, inevitably there are a few people for whom the State does not provide. Sometimes their problems are medical, sometimes social, while yet others fall in the ill-defined area where both disciplines meet. Moreover, the number of individuals with any particular problem is likely to be small, so that their plight remains unnoticed, while their chances of forming a pressure group are remote. Private charity has an important part to play in helping these people, as has reliable advice on the full use of the community services available. Starting this week we are printing the first (p. 603) of a series of articles by a special correspondent drawing attention to the needs of the “Forgotten,” how these are being met, and what more could be done. This will include accounts of a person with total paralysis, epilepsy, motor neurone disease, and multiple sclerosis, as well as the difficulties faced by a single woman looking after an aged parent, and a teenage unmarried mother. We hope that these will highlight the different problems that remain even in an affluent society.