proximal jejunum to absorb glucose. The trapping of available carbohydrate within intact cell walls and alterations of the physical characteristics of the intraluminal contents by unabsorbable carbohydrates may both result in reduced availability of glucose for absorption in the proximal small bowel while increasing its availability in the distal small bowel. The adaptation of the proximal jejunum may then be reversed, resulting in a flatter glucose tolerance curve.

It is possible that some diabetic patients might benefit from treatment with wheat bran or other dietary fibres and unavailable carbohydrates.

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Student counselling

SIR,—Your leading article (13 March, p 605) is timely. It does not, however, adequately emphasise weaknesses in the present situation in Britain nor point to the future. What is the prevalence of student problems? How should they be managed? How might they be diminished or prevented?

A review of prevalence studies[1] suggests that, over all faculties, 1-5% of students suffer from serious personality problems or psychiatric disability and a further 10-20% from a miscellany of difficulties: minor psychiatric disturbance, problems with living, study difficulties,[2] psychosocial and psychosexual problems,[3] psychosomatic disturbances. This minor morbidity can lead to considerable personal unhappiness, and, more relevant, is eminently treatable. Management involves counselling techniques[4] as well as other forms of treatment not mentioned in your article, principally psychotherapy, both psychodynamic[5] and behavioural.[6] All three forms of treatment should be available and crucially, as you mention, there should be close harmony with the academic tutorial system. From experiences[7] I have no doubt that liaison between these helping services is far more effective than either academic or psychological guidance alone. These treatment techniques are as yet available only to a small—it is not accurately known how small—percentage of students in higher education, in both the university and non-university sectors. Medical schools in London are conspicuous for their backwardness in introducing any comprehensive helping service relevant to students other than formal psychiatric treatment, including psychotherapy, provided by psychiatrists.

With current emphasis rightly on preventive medicine, other related measures should be considered which might lessen the burden on counsellers and others. With sexual and relationship problems so important in the student age group, sex education[8] is surely high on the list of priorities, especially for medical students, who should, as doctors, be in a position to pass on their expertise to their patients. Comprehensive sex education needs the co-operation of persons with special areas of expertise—anatomy, physiology, sociology, psychology, psychiatry, gynaecology—but this has been achieved elsewhere as, for example, in Denmark.[9] As with counselling, so with sex education, London medical schools keep their heads firmly in the sand so that those, like me, with a special interest in this area of medical education may be offered two one-hour periods in a behavioural science course to teach human sexuality. Given these constraints, one is either arguing with the sexually experienced student or frightening the inexperienced.

The time has come to make a positive contribution to the personal fulfilment of students. Counselling, psychotherapy, behavioural modification, co-ordination with academic tutors, and sex education represent a systematic attempt to reduce the incidence of new problems or, where prevention fails, to provide a more effective and co-ordinated programme of management.

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Assessment of preoperative cases

SIR,—Dr P R Fletcher's letter (6 March, p 580) commenting on Dr T W Ogg's article (10 January, p 82) stimulated me to survey 230 outpatient cases I had anaesthetised using a questionnaire similar to that used by Dr Ogg. The series included 133 dental and 97 genitourinary cases. The dental cases were evenly distributed in regard to sex but in the genitourinary series 61·8% were males. The age distribution was as follows.

Age (years)	No of patients		
	Dental	Genitourinary	Total
2-16	67	0	67
17-45	59	43	102
46-65	6	35	41
66-83	1	19	20

Of the 169 patients aged 2-45, 10·1% had medical histories and 31·3% were on concurrent drug therapy. The corresponding proportions of the 61 patients aged 46-83 were 19·6% and 32·6% respectively. Of the patients aged 2-45, 4·7% gave a history of allergy, and of those aged 46-83, 6·5% gave a similar history. No patient under 17 admitted to smoking, but 33·3% of those aged 17-45 and 45·9% of those aged 46-83 did so.

Anaesthesia was postponed in no case in the series, but consideration was given to one girl aged 17 weighing 15·5 kg who presented for exodontia cyanosed and with marked finger-clubbing. She was not dyspnoeic, however, and perusal of her questionnaire revealed a history of chronic cystic fibrosis and that she was on ampicillin.

The questionnaire appeared to be a useful screen in all age groups, but undoubtedly the institution of preoperative clinics would be the ideal.

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Spasmolytics for postoperative bowel contractions

SIR,—In the search for a suitable spasmolytic agent to antagonise neostigmine-induced bowel contractions (Drs E N S Fry and S Deshpande, 13 March, p 646) hyoscine butylbromide was likely to prove disappointing. Most workers have found its nicotinic to predominate over its muscarinic actions in keeping with its quaternary ammonium structure so that it is a poor antagonist of the local accumulation of acetylcholine.

Alternatives might include another anticholinergic drug, propantheline bromide, with strong selective muscarinic properties in addition to its nicotinic effects. Herxheimer[1] reported a spasmolytic potency of 3-75 in comparison with atropine, while the antisialogogue potency was 0·76 and the heart acceleration potency was 0·70. As with hyoscine butylbromide, however, duration of action was brief.[2] Among those spasmolytics acting directly, papaverine may have a place as it is reported to have 50 times the potence of hyoscine butylbromide in inhibiting barium chloride spasms.[3] Mebeverine in turn was found to be more potent than papaverine by Lindner,[4] and Connell[5] was able to demonstrate a decrease in colonic muscle motility lasting 10-35 minutes in man after 50 mg given intravenously.

While searching for the ideal spasmolytic for use in conjunction with neostigmine one would like to have some more information to what extent ruptured intestinal anastomoses are a problem in association with neostigmine, bearing in mind that all the subjects in Bell's study[6] had had steroid therapy and that anastomotic leakage was demonstrated radiologically with barium, not clinically.

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High intestinal lactase in Pakistanis

SIR,—Though I have no means of questioning the technical validity of the paper by Drs S M Rab and A Baseer (21 February, p 436), I would like to make the following comments on their ethnic conclusions.

(1) Punjabis, though depicted as a Mediterranean race, are actually a product of the