assessment, painstaking attention to technique during implantation, and the greatest possible care to avoid infection.

8 Kaufman, J J, British Journal of Urology, 1975, 45, 646.

Pancreatitis

Most clinicians recognise two principal types of pancreatitis.1 Acute pancreatitis is a serious and painful illness, which is usually short lived but carries an appreciable mortality and a fearsome list of complications. While it is generally self-limiting there may be relapse. Surgery should be avoided if possible, though it may be required for diagnosis2 or the management of sequelae. In contrast, chronic pancreatitis is associated with permanent and perhaps progressive loss of exocrine function and may also cause irreversible diabetes mellitus. It frequently results in persistent or intermittent abdominal pain, which may not respond to analgesics, and, indeed, may occasionally drive its victims to suicide.

The two known causes of pancreatitis are biliary disease and alcoholism. White3 stated that in 559 cases of acute pancreatitis biliary disease was associated in 74% and alcoholism in 5·5%. In contrast, of 258 patients with chronic pancreatitis, 75% were alcoholics and only 1% had biliary disease. Certainly studies in Britain have shown that biliary disease is common or usual in patients with acute pancreatitis.4-6 Alcoholism was a rare4 but now appears to be a more frequent cause.4 Nevertheless, in chronic pancreatitis in Britain the association with alcoholism has been modest7-9 compared with reports from Europe and the USA, where up to 100% prevalence has been reported.10

These data suggest that we should be cautious in interpreting reports of treating pancreatitis from other countries, where the nature of the disease may be different. There are some lessons to be learnt, however, particularly for those patients who require resection of the pancreas or other surgical procedures for chronic pancreatitis. The Mayo Clinic’s experience11 of 137 patients with chronic pancreatitis treated by surgery—54 with resection—showed that the abuse of alcohol, absence of gallstones, and presence of pancreatic calcification, steatorrhoea, or diabetes were unfavourable indicators. Furthermore, there was an appreciable late mortality (20% in a mean of 44 months), despite a low postoperative death rate.

In a more extensive review in Michigan of 600 patients treated with surgery, 149 had pancreatic resection for chronic pancreatitis.12 This series included 117 alcoholics, but only 11 patients had gallstones, suggesting that this was not important aetologically as this was roughly the number expected by chance. Nineteen patients had a proximal operation (pancreatoduodenectomy). On various indications the others had either partial (40-80%) or subtotal (80-95%) distal pancreatectomies. Three patients died postoperatively, and 30 died later, but about half the operations produced a completely satisfactory result, with the presence of alcoholism being the most important factor in predicting failure to improve.

The only statistically significant difference between the results of subtotal and partial resection was the higher prevalence of diabetes after the former. Overall there were fewer untoward sequelae after partial resection, and the authors recommend that ideally no more than 80% of the gland should be resected.

In a disease which is so difficult to manage it would be logical to direct more effort to prophylaxis. Clearly chronic pancreatitis will provide more work for surgeons in Britain unless we can find some way to curb the rising consumption of alcohol.

1 Sarles, H, Bibliotheca Gastroenterologica, 1965, No 7, VII.
6 Trapnell, J E, and Duncan, E H L, British Medical Journal, 1975, 2, 179.
7 James, O, Agnew, J E, and Bouchier, I A D, British Medical Journal, 1974, 2, 34.

Child health and environmental lead

Overt lead poisoning in childhood is uncommon in Britain, but, though the symptoms are variable and a high index of suspicion is needed on the part of the clinician, the diagnosis is usually clear.1 For lead poisoning to occur seems to require not only a source of lead but also that the child concerned should be at a specific developmental stage, and both the parent-child relationship and the presence of social and financial deprivation also seem relevant. Sources of lead in such cases include dirt, red lead in putty, and chips of lead paint; more recently lead-containing cosmetics such as surma2 and an imported baby tonic3 have been incriminated, especially in Asian immigrant communities. Much lead poisoning may be prevented by restricting the use of lead compounds in the home environment; but the problem remains of whether environmental lead—in air, dust, and water—produces subclinical lead poisoning and whether this can result in retardation of psychomotor development in the growing child.

Moncrieff et al4 drew attention to the frequent finding of raised blood lead concentrations in children with mental handicap, severe behaviour disorder, or pica, most of whom were not clinically poisoned. Since then a dispute has centered on the clinical significance (particularly in relation to mental handicap and behaviour disturbance) of blood lead concentrations below those proved to be toxic but nevertheless indicative of excessive exposure. Pollution of the environment by lead in air, dust, and water, has become a highly emotive

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1 Sarles, H, Bibliotheca Gastroenterologica, 1965, No 7, VII.
6 Trapnell, J E, and Duncan, E H L, British Medical Journal, 1975, 2, 179.
7 James, O, Agnew, J E, and Bouchier, I A D, British Medical Journal, 1974, 2, 34.