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MJ carried out work on this study as a fourth-year research project.

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If I Had . . .

A melaena

A PATON

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Introduction

The scene is a hospital ward. I am conducting a ward round and suddenly feel faint and queasy. I sit down beside the bed; it must be the overheated ward or the tedium of the round. But as I get up, the world starts swimming and I have an overwhelming desire to defaecate, so that I have to rush to the ward lavatory. I pass a large melaena stool, and almost faint when I try to stand up, but, after sitting for a few minutes, feel better and walk feebly back to the ward. The shocked faces that greet me mirror my own concern, and I am led meekly by sister to her office.

Decisions

The first decision is whether to go home. I have a strong antipathy towards hospitals and firmly believe that for many serious conditions home is the best place to be, provided it is properly equipped, not only in the utilitarian sense but also with ever-loving family and a caring general practitioner. But gastrointestinal bleeding? A true haematemesis—and I don't mean the vomit that contains streaks of blood—or a true melaena probably means the loss of at least 500 ml blood and therefore requires admission to hospital. (I must confess that if it had happened at home I might have stayed put.) So where and by whom? Naturally, I believe that gastrointestinal bleeding is a medical problem best dealt with in a general ward. I have no sympathy for takeover bids from surgeons or intensive care units. So I elect for a general physician used to emergencies, with the knowledge that he would co-operate with a general surgeon of similar experience if the need arose.

I have always thought, and it's not very original, that the clue to proper treatment of emergencies is to get your priorities right. If you have a serious haemorrhage I imagine the first thing you want is reassurance and peace and quiet; in a word, sedation. Nowadays this seems to be a wicked thought, for mainly irrational reasons engendered by populist ideas and the obsession with technology. In spite of possible disadvantages, there is still much to be said for an injection of morphine, or perhaps omnopon, to minimise the risk of vomiting, and my favourite alternative remains intramuscular sodium phenobarbitone. But I am prepared to settle for diazepam if my physician insists.

Resuscitation

A specimen of blood is then taken, not only for grouping and cross-matching, but also for estimating liver function tests, urea and electrolyte concentrations, a full blood count (including platelets), and prothrombin time. An intravenous drip is set up and saline infused *slowly* while waiting for blood, which is what I need. Plasma or dextran might be given if I am shocked, but I would strongly resist the current enthusiasm for central venous pressure lines. Most bleeding can be managed by conventional means.

Once the blood is running I feel safe, provided my attendants resist another prevalent tendency to give large quantities. Meanwhile the nurses are doing their bit with hourly pulse and blood pressure measurements, and keeping a measured record of any further blood loss. If the ward sister is one of those who can "smell" bleeding that is an added bonus. Fluids and light food are allowed in most circumstances; it is extraordinary how persistent is the obsolete practice of "nil by mouth," so many years after Avery Jones showed that feeding actually improved the outlook. Likewise a Ryle's tube is unnecessary and may be positively harmful.

Investigation

For the patient the precise cause of the bleeding has a fairly low initial priority, and it is really only at this stage that the

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physician needs to start probing. He will, of course, be aware that a quarter or more of patients with chronic ulcers have no dyspeptic history; and, in spite of the controversy over what drugs do to the gastrointestinal mucosa, he will have little doubt that they are connected with bleeding. This applies to alcohol and a wide range of drugs, in addition to anti-inflammatory agents, and newly introduced substances will be treated with particular suspicion. While perhaps 90% of gastrointestinal bleeding is due to peptic ulceration, erosions, and oesophageal inflammation, he will appreciate that the absence of splenomegaly does not rule out portal hypertension and he will be on the look out for rarer causes. I have too often seen patients with conditions like hereditary haemorrhagic telangiectasis, cirrhosis, and blood dyscrasias sent to the operating theatre without a correct diagnosis not to be apprehensive.

It would be nice if the physician brought his favourite surgeon to see me at this time, not to ask him to operate, but so that they can view me at my best should bleeding recur. Many people will want to keep up with the Joneses by considering emergency endoscopy or barium studies, or both. I have recently celebrated my silver jubilee as an enthusiastic endoscopist, but I am also a coward and therefore don't feel that every patient who bleeds should have an emergency endoscopy. Besides, to produce a diagnostic yield of over 90% it must be done within 24-48 h and this tends to interfere with other work and with leisure. We endoscopists need reminding, too, that "the least valid licence for performing endoscopy is the simple possession of an endoscope,"[1] and perhaps the best way of doing this is to have to undergo the ordeal ourselves. Emergency endoscopy has not reduced the mortality from upper gastrointestinal bleeding, which remains obstinately around 8-10%, nor is it yet clear whether the undoubted diagnostic value confers any therapeutic advantage.[2] Like all invasive procedures, there is a small risk of complications though the rate is acceptably low: 0·2% in over 200 000 routine endoscopies where every possible complication, however minor, was included.[3]

Emergency barium studies are less reliable, unless the double contrast technique is used, but perhaps safer. They and angiography may be needed in the exceptional case and in my view are best confined, like endoscopy, to the 10-25% of problem cases. Requests for "barium-meal and follow-through" examination are both wasteful and unimaginative, and it's a pity they are still condoned by radiologists. Seeing patients over the years with gastrointestinal bleeding, I am struck by the frequency with which a cause can be suspected by stopping to ask questions instead of rushing off to the *x*-ray department or endoscopy theatre.

Further bleeding

Bleeding stops in most patients within 48 h, and if this happened to me I would want to go home. Except for chronic ulcers and portal hypertension, where bleeding may recur, and rarer conditions which may need further investigation, there is no justification for keeping people who have had a melaena more than a few days, provided their homes are satisfactory. If bleeding persists or recurs—and I do not mean the passage of stale melaena stools, which often alarms the unwary—and the cause is not clear, endoscopy is necessary. I am also a strong believer in early operation: a patient is unlikely to be in good shape after he has been repeatedly resuscitated with multiple blood transfusions. There are, of course, other things that can be done for those who are considered unsuitable for surgery, such as local treatment of bleeding oesophageal varices or injecting vasopressin or clotting agents via a catheter in the coeliac axis. It is too early to be dogmatic about cimetidine; it may be useful for erosions but less so for chronic ulcers. In any case its use seems slightly illogical to me, since bleeding itself may inhibit gastric acid secretion, an effect which sometimes lasts for weeks.

So what should the surgeon do? If he were unfortunate enough to find varices the most logical emergency procedure seems to me to ligate them through an incision in the stomach. He must not embark on a portacaval shunt, however good my liver function. If there were erosions or a duodenal ulcer he would perform a vagotomy and pyloroplasty (highly selective if possible), with oversewing of the ulcer if it had eroded a blood vessel. If there was a gastric ulcer which looked benign I hope he would try the same operation, with local excision if he wished, but he might prefer to do a Billroth I gastrectomy. If a carcinoma was the cause I trust he would have the good sense to do nothing except a biopsy (mandatory however "obvious" the diagnosis seems to be) and prescribe large doses of heroin to be given regularly so that I remain in euphoric ignorance during the short postoperative period. If no cause can be found after a careful look at the inside of the stomach, oesophagus, and duodenum he should close me up without doing anything more. I look forward to waking up in the medical ward from which I have come, with the minimum of restrictions in the way of drips and gastric tubes, and being allowed home inside the week with suitable instructions for the district nurse.

Apologia

In spite of Harold Ellis's recent plea[4] for doctors to be treated with the same thoroughness as other patients, I am prepared to accept an increased risk, if it means some restraint in the employment of the latest investigations and heroic treatment. Having demanded so much of so many, I naturally hope to be a model patient, passive and unprotesting. Judging by the rare occasions on which I have been more than mildly ill, I guess that my behaviour would be intolerable.

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How much reliance can be placed on an abnormally high mean cell volume, in the absence of anaemia, as evidence of alcoholism? Are there any supplementary tests which might increase this reliance?

There are many causes of a high mean cell volume (MCV) besides alcoholism, but anyone who treats alcoholics will confirm the value of the MCV as a screening test. Indeed, it has been used for this purpose in epidemiological surveys in Europe. If confirmation is needed estimation of the serum concentration of glutamyltranspeptidase is particularly helpful.

What treatment is advised for Ewing's sarcoma of the long bones?

Adjuvant chemotherapy is changing established traditions in the treatment of almost all malignant bone tumours. Until the results of trials are known unqualified support of one particular regimen would be unjustified. In the past, irradiation alone was usually advised because early response was dramatic and amputation abhorrent in such a lethal tumour. But even before the use of chemotherapy amputation probably resulted in a higher chance of survival.[1] Given therefore that no metastases can be detected, primary amputation followed by adjuvent chemotherapy would probably be most effective. Irradiation and chemotherapy are a perfectly acceptable alternative, particularly in the arm and in children over 12 when considerations of limb shortening after the necessarily high-dose irradiation are less important. Such functional considerations may indeed be paramount at a time when there is still no clear evidence in favour of either regimen.[2]

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