can be more perfectly enjoyed, but the import of sterile water from the U.S.A. for cystoscopic purposes is surely the height of extravagance. That our administrators can condone this and other expensive gimmicks some of us find a little hard to explain and suggest that Mr. Shaldon's letter will provoke a flood of similar criticism which in the fullness of time may put an end to this administrative folly.—I am, etc.,

Leith Hospital, Edinburgh

I. E. W. Gilmour

Dangers of Silent Gall Stones

Sir,—In your leading article (22 February, p. 415) you advocate elective cholecystectomy whenever gall stones are discovered. The evidence in the literature, as recently reviewed,1 and the argument in your article are far from conclusive. The logic underlying a decision to advise cholecystectomy for a symptomless condition must depend on the incidence of complications, the possibility of developing carcinoma of the gall bladder, and the mortality of elective cholecystectomy. The most detailed study2 (covering 24 years) suggests that the course of symptomless gall stones showed that 49% developed symptoms but only two-thirds of these had trouble sufficient to merit cholecystectomy. Further, the incidence of major complications was 18%, and twice as frequent in the group who had originally non-functioning gall bladders on cholecystography. The mortality of the group with silent stones was similar to that of the study group as a whole, suggesting that elective cholecystectomy did not reduce mortality. It has been shown that patients with silent stones tend to develop symptoms within five years,3 not as suggested in your article in a linear fashion.

The danger of a conservative policy in the management of silent stones is that there will be an increased incidence of carcinoma in the elderly age groups, but Sato and Matsushiro4 found that 74% of patients who were admitted with acute cholecystitis had had previous symptoms and only 20% of those patients who had had cholecystitis had been admitted in the acute phase. Thus the occurrence of acute cholecystitis as a complication of the conservative management of silent stones is unlikely to be a major contraindication to this policy.

Despite the well-known association between gall stones and carcinoma of the gall bladder there is no evidence that elective cholecystectomy for silent stones could be advocated on the basis that 50% of subjects will be symptom-free for life, cancer of the gall bladder is most unlikely to be a significant complication, and the mortality is similarly unlikely. The course is pursued. A more logical approach to this problem is to advise cholecystectomy for those patients who on detailed questioning are found to have symptoms referable to the gall bladder and for those who have a non-functioning gall bladder at cholecystography. The remaining patients should be told to report to their doctor at the onset of symptoms, and elective cholecystectomy should then be performed at the earliest opportunity to avoid increased morbidity and mortality from acute cholecystitis.—We are, etc.,

R. C. G. Russell
HUGH DUDLEY
Surgical Unit,
St. Mary's Hospital Medical School,
London W.2

5 Sprio, H. M., Clinical Gastroenterology, p. 739.

Merrick Report and Asian Doctors

Sir,—The Merrick Report1 has made most Asian doctors angry. When the N.H.S. was in danger of collapse Asian doctors went not only welcome but were encouraged to come and work here. Now they are being humiliated in a general attack, though a big majority has faithfully and efficiently served the N.H.S. Britain has a right to impose conditions on new entrants, and it is reproachable to kick the established ones in the teeth. Would it not be kinder and more honest to halt immigration of all overseas doctors than to allow them to come and then submit them to indignity and humiliation?—I am, etc.,

D. R. PRINCE PREM
President, Standing Conference of Asian Organizations in the U.K.


Medical Problems of the North Sea

Sir,—Your leading article (5 April, p. 5) on medical implications of oil related industry was both timely and interesting. It appeared, however, by concentrating on the problems of the northern North Sea, to ignore areas south of Yorkshire as far as Britain is concerned and failed to comment on the fact that similar problems are faced by our colleagues in Scandinavia and Europe. While it is probably true to say that the sea is deeper and the climatic conditions worse in the north of the North Sea than in the southern area, I think it was a pity you failed to stress the importance of all medical groups who face the problems of the North Sea sharing their information and experience. The work seems to be most likely to be of help to all who work in the North Sea.

My colleagues and I, who have worked in the southern North Sea for over eight years, are keen to learn from the experience of other groups and also to make available any useful information that we may have gathered in the course of this time. While

I am proud of my forebears from Aberdeen, I would hate to think that your leading article suggests that the problems of offshore medicine in the North Sea are confined to those on the coasts of Scotland. —I am, etc.,

I. K. ANDERSON
Royal Norfolk and Suffolk Yacht Club, Lowestoft

Tailored Treatment for Varicose Veins

Sir,—I would like to agree with the spirit, if not the letter, of your leading article (15 March, p. 593). The principle you enunciate is one I have accepted for some years now—namely, that no single treatment suits all patients with varicose veins. This surely must be the lesson of the post-war stripping era, and as your article makes clear, evidence is now coming to light that condemned sclerotherapy as an all-or-nothing cure. There is no need to reject Fegan's simplistic approach has been the logical or desirable treatment for varicose veins; I cannot accept, for instance, that all varicose veins are associated with incompetent perforators, nor can I accept that varices become varicose secondarily—that is, from below up—when patients will describe a distinct process by which veins appear progressively and spread distally. However, I would agree that Fegan has made a considerable contribution to the treatment of this condition by defocusing us from the equally illogical regimen of rounds of stripping veins if they have not been treated, it would have been necessary to invent him. Stripping was a failure because so often it removed a normal long saphenous vein leaving the incompetent tributaries, and this logical treatment of varicose veins is based on the following. (1) No injection treatment can be practised proximal to the knee. (2) If sclerotherapy is indicated evidence should be sought for incompetence at the saphenofemoral junction, as it has been shown that if this is present the early recurrence rate is higher than if there is no incompetence at this point.3 It is not easy to establish clinically whether the saphenofemoral incompetence is present. A palpable thrill or a saphenous varix, while constituting positive clinical proof, may be absent in many cases when functional incompetence at this junction is present. Therefore, as a different manoeuvre must be prepared to explore the groin more often, while not necessarily ligating any veins unless they are obviously incompetent—that is, a proportion of negative explorations must be anticipated. (3) The best way to remove the obvious varicosities is a direct attack on them. It has always been a source of frustration that simple ligation, even if done at multiple