sutured over it. Closed drainage may be made for 24 hours. This leaves no deformity or respiratory disability and the less obtrusive scar is appreciated by some patients. This operation is a great advantage in the unusual presence of an infected tracheotomy stoma. The incision can, of course, be extended across the stenium if an unexpected invasive tumour is found.

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Sexual aspects of medicine
Sir,—As a very experienced ward sister who has worked in the direct care of surgical and medical patients throughout my life, I should like to suggest that your recent series of articles on "Sexual aspects of medicine" should be reprinted and made available to all health service workers, whether doctors or nurses, social workers, or other paramedical personnel. Such useful work as this cannot be a substitute for as-and-as reading for medical and nursing students and could be used in postgraduate courses and seminars. A satisfactory sex life within a committed partnership is an essential aspect of well-being. When such an experience of love is more difficult by physical disease patients are so often left with little advice as to how to re-establish their former relationship. This applies to every sphere of medicine and much surgery.

Mr A G Amias (14 June, p 608, and 21 June, p 680) dealt fully with the problems of the patient after gynaecological surgery. But what about so many others who have operations which subsequently affect the physical and emotional capacity to re-establish a satisfactory sex life? Patients who have had major operations on the back or limbs rarely get any sexual advice from the surgeon. It is often left to others, and that includes, primarily, the experienced ward sister if she is motivated to help. Patients with a colostomy or ileostomy often experience severe physical and emotional problems in re-establishing a happy sex life and are glad of advice and help. Loss of lower limbs in young adults affects their sexual life and happiness and much more sympathy and empathy should be shown to these patients. The burnt patient is another example of one who may experience anxiety and difficulty because of disfigurement of his or her body or of some deformity of the sexual organs themselves.

Cardiac patients are often given a battery of drugs to take, some of which affect their libido. They may have accompanying depression due to loss of job through ill health or family responsibilities with which they find themselves unable to cope. Psychotropic drugs may be prescribed for this and some of these also affect the patient's libido, apart from the depressed state. A mixture of such drugs can cause impotence in a man, and his worries over this may be greater than those caused by his heart disease and are often shared by his wife. Postoperative cardiac patients also need help. Some seek advice as to whether their "new hearts" will take the strain. One patient was told by his general practitioner that at his age (44) the time had probably come to "call it a day." To my mind there was no medical need for this as the patient was not acutely ill and abstinent and was just as much hypertensio and aggravation to the man and his mind as does his physical condition. This man subsequently had an operation and afterwards asked me if "sex was still forbidden." I advised him to have gentle sex with nothing too rough at first and to resume his normal sexual life gradually according to the needs of himself and his wife. Two years later he told me that since he had spoken to me he and his wife had never known such a wonderful sex life.

There are few fields of medicine and surgery which do not affect, physically, emotionally, or both, the patient's ability to establish or re-establish the happy sexual life which is the essential and primal joy of true manhood and womanhood. I therefore feel it the duty of all those concerned for their patients' welfare to give "total patient care" and include in it this aspect of their life by sympathy, empathy, special care and understanding, advice, counselling, or referral for special help. There are many patients who do not receive this care to the extent that they should.

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**This series of articles is to be reprinted in book form.—Ed, BMJ.**

Adverse reactions to prazosin
Sir,—We were interested to read the experiences of Drs J Rees and H J H Williams and others with prazosin-induced hypotension (6 September, p 593). Since we published our first observations1 we have treated 30 hospital inpatients with this drug. Three have become hypotensive within an hour of the 2 mg tablet. When one patient became unconscious for 1½ hours and developed mild fever lasting 12 hours. In all three symptoms of hypotension and malaise persisted for about eight hours.

We originally1 stated that the manufacturers of prazosin should produce a low-dose tablet which might produce a less drastic effect in patients at risk of hypotension and unconsciousness. Two of our three patients who collapsed after 2 mg of prazosin were given 0·5 mg of the drug, having taken no prazosin for one or two weeks. In neither was any adverse reaction observed. The 0·5-mg tablets were donated by Pfizer Ltd.

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Genetics of duodenal ulcer
Sir,—The evidence for a genetic predisposition to duodenal ulcer is not "modest" as stated in your leading article (6 September, p 557) nor merely based on the original family studies.1 The Danish twin data suggest that genetic and environmental factors are about equal in importance in this disease.2

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Sin—I was a little surprised that your leading article on this subject (6 September, p 557) omitted to mention the known differences in the chemical structure of gastric and duodenal mucus between the two blood groups ABO(H) and the ABO group and secretor status. The molecules of mucus are glycoproteins, consisting of a peptide chain with carbohydrate side-chains attached to it. In ABO blood group secretors there is an additional fucose sugar at the end of the side-chains which is not found in non-secretors. In A, B, and AB secretors there is a further additional sugar at the end of the side-chains, which is N-acetylgalactosamine in group A secretors and galactose in group B secretors.3 The lower incidence of duodenal ulcer in the secretors of blood group substances is possibly explained by the extended side-chains which may improve the capacity of the mucous to protect the mucosa against damage by gastric acid and pepsin. Likewise, the lower incidence of duodenal ulcer in A, B, and AB subjects than in group O subjects may be related to the additional N-acetylgalactosamine or galactose in the gastric and duodenal mucus of A, B, and AB secretors. This cannot be the whole story, because in non-secretors there are no side-chains in the structure of mucous whatever their blood group and yet...