out accurate fracture reduction, and movement of bone within the wires can take place. In a bone as heavily stressed as the tibia this is almost impossible to avoid. In other situations, as for instance the fibular component of certain ankle fracture-dislocations, they can be of very little value.

It would be a pity for the appropriate use of encircage wiring in fracture treatment to be discredited by further repetition of this long-standing misapprehension concerning the reasons for its failure when used inappropriately.

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Epipodophyllotoxin VP 16213 in acute non-lymphoblastic leukaemia

Sir,—Professor F Jacobs and his colleagues (15 February, p 396), reporting the use of VP 16213, an epipodophyllotoxin derivative, in the treatment of acute non-lymphoblastic leukaemia expressed their interest in hearing of similar experiences.

We have recently published some of our results with this drug in treating acute leukaemia.1 It was particularly interesting to us to find that VP 16213 seems to be active not only in acute myelomonocytic leukaemia (AMML) as previously reported,2 but also in acute myeloid leukaemia (AML). We treated seven patients with AML. All were in relapse following extensive previous treatment to which they were resistant. VP 16213 was used alone in a dosage of 150 mg/m² daily given as a continuous infusion for three consecutive days. Of the seven patients treated, one attained complete remission, another very probably a complete remission, and a third patient had a good partial remission.

On the basis of these results we have since used this agent in the following combination: vincristine 1 mg every 12 hours for two doses on day 1; adriamycin (doxorubicin) 60 mg/m² on day 2; 6-thioguanine 200 mg/m² daily on days 2-6; VP 16213 100 mg/m² daily as a continuous infusion on days 2-5. So far this combination has given us two complete remissions in the first four patients treated. These were all patients with AML in a first relapse after other primary treatment.

The Swiss Group for Clinical Cancer Research is now using this combination in a co-operative study for all patients relapsing after primary induction therapy with cytotoxic arabinoside and daunorubicin. It is still too early for even preliminary results of this co-operative trial to be reported.

On the basis of experimental data3 we are at present attempting to assess the value of VP 16213 in combination with cyclophosphamide in the treatment of acute leukaemia. This could be of interest if it leads to an improvement of the well-known COAP regimen.4 We also would be most interested to hear of the experience of others using similar programmes.

We thank Sandoz Ltd for supplying VP 16213.

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Medical aspects of North Sea oil

Sir,—I am the house surgeon at the Gilbert Bain Hospital in Shetland and read with interest an editorial (26 September, p 756) summing up the findings of the working party on the medical aspects of North Sea oil.1

I wish to point out how very stretched the hospital service is in Shetland by oil industry casualties. The hospital is staffed medically by one consultant surgeon and one pre-registration house surgeon, both of whom are on call all the time. No provision has been made for adequate staff to deal with the extra burden of injuries which the hospital is required to treat.

Working on permanent duty has become intolerable and medical students are occasionally employed as locum house officers to allow the house surgeon some time off. It is ethical that the North Sea oil industry should rely for its surgical back-up on one surgeon and a medical student, who may also be required to cross-match blood.

The limelight of the national press has recently fallen on Shetland, illuminating new and useful wealth on Britain’s shores. What it does not show is the far from adequate situation which really exists here in the hospital.

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Sterilisation: laparoscopy or laparotomy?

Sir,—The importance of this debate is underwritten by the space that it occupies in your correspondence columns. The long-awaited stone-age procedure is still seen by some as the only acceptable form of contraception. It is marginally more acceptable to a patient than a laparotomy, but the benefits of laparoscopy are rarely acknowledged. The technique is simple and has minimal risks. In most cases it will be of even benefit to one or both partners. The new technique is therefore gaining widespread acceptance.

A woman who consulted me had found out that she was pregnant. She already had a man and was not ready to have a child. A laparotomy was suggested. After explaining the benefits of laparoscopy, she decided upon this method and her pregnancy was terminated successfully by this technique.

The procedure is simple and has minimal risks, and the patient is able to return to work immediately after the operation. The technique is gaining widespread acceptance and I think it is our duty to ensure that all women who require contraception are made aware of the benefits of laparoscopy and are offered the choice of this technique.

N D DAVIES
Aberdeen, Scotland


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