Late mortality after vagotomy and drainage for duodenal ulcer

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a place where non-interventional intracranial care was practiced. And such places would not have been virtually extinguished.

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1 Butler NR, Bonham DG. Perinatal mortality. Edin-
burgh: Churchhill Livingstone, 1983.
3 Tew M. Facts, not assertions of belief. Health and
4 Tew M. Effect of statistical objections on personal
9:444-6.
5 Tew M. Understanding intracranial care through
6 Tew M. The unimportance of the newborn. In:
Marsh GN, ed. Modern general practitioner ob-

Immunisation, rehydration, and transfusion
Sir,—Dr Katherine Elliott reminded us of
the importance of devising simple practical
solutions to the common medical problems
in areas without high technology medicine
(5 May, p 1364). I was, however, disappointed in
the cursory approach to blood transfusion.
Several misleading suggestions were made.
The use of dried plasma has been largely
discarded because of its hepatitis risk and
inconvenience. It has been replaced by "plasma
protein fraction" which is expensive and often
in short supply. Synthetic plasma substitutes
such as dextrans and gelatines may be more
suitable for treating burns or moderate blood
loss.

Blood transfusions for severe haemorrhage
will be universally required. The staff involved,
however, require appropriate knowledge of
the rudiments of blood bank organisation and
serology and also training in simple reliable
techniques for grouping and compatibility
testing. The difficulties in screening for trans-
missible blood born diseases will restrict
transfusion to obvious life saving attempts.
Blood collected from donors requires careful
anticoagulation, and containers suitable for
other intravenous fluids will not readily be
adaptable. Plastic packs prefilled with sterile
preservative anticoagulant solution are the
only practicable option. Current anticoagulant
formulations allow at least 35 days refrigerated
storage. Specifications need to be redefined in
terms of cost benefit relations and conditions of
use appropriate to the country concerned.

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Late mortality after vagotomy and
drainage for duodenal ulcer
Sir,—Mr P C H Watt and others (5 May, p
1335) have found that colorectal carcinoma
is significantly increased after gastric surgery.
We recently carried out a retrospective case
control study of 289 patients with a histological
diagnosis of colorectal carcinoma and a similar
number of age and sex matched hospital controls.
Significantly more patients with colorectal
 carcinoma (n=27) had undergone gastric
surgery compared to the controls (n=13: McNemar’s test x²=4.7, p <0.05). The pre-
valence of peptic ulceration shown endoscopically
or radiologically was similar in both groups
(37 versus 30 respectively). Our study sug-
gests that it is the gastric surgery itself and not
the ulcer diathesis or the smoking habits of
these patients which predisposes them to
colorectal carcinoma.

Bile salts have a promising effect on colorec-
tal carcinoma,1 and there is altered bile salt
metabolism2 and increased flow of bile salt
metabolites through the colon after gastric
surgery.3 Alteration in bile salt metabolism
could be the cause of the increased incidence
of colorectal carcinoma seen after gastric
surgery for peptic ulceration.

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1 Reddy BS, Watanabe K, Weisburger JH, Wynder EL.
Promoting effect of bile acids in colon carcinogenesis
in germ free and conventional 1344 rats. Cancer Res
2 Domellof L, Reddy BS, Weisburger JH. Microflora of
and cholesterol and alkaline reduction after
partial gastrectomy. Am J Surg 1930;140:291-
2.
3 Blake G, Kennedy TL, McKelvey STD. Bile acids and

Treatment of myopia
Sir,—I should like to present an alternative
view of the treatment of myopia to that of
Mr Patrick Trevor-Roper (17 December, p
1822).

Myopia is the most prevalent eye disease,
and the third commonest cause of blindness,
in the developed world. In the United States
alone some 42% of people suffer its in-
convenience and complications. Typically it
arises in childhood, but its complications
are present in adulthood. It plays a part in the
actiology of 95% of cases of retinal detach-
ments, and of some 20% of its sufferers develop
cataract.3 In contrast, open angle glaucoma (a "common"
eye disease) affects a mere 1.1% of the elderly.

It is possible now to arrest the progress of 95% of
cases of myopia in childhood by the use of
prism controlled bifocals.4 The remaining 5% of
cases can be arrested by the use of apex clear Ruben
Offset contact lenses, which leave the corneal centre
underpressed.5 What aetiology allows such treatment
to be effective?

Four assessments from work starting in 1960
suggest that 90% of cases of myopia could be
environmentally caused and 10% could be
hereditary.6

Workers in Japan first showed that heredity
was responsible for no more than half of cases, and
it was shown in 1964 by radioisotope measure-
ments that the vitreous pressure in monkeys was
affected by environment.7 Studies in children and
adults8,9 show that patients with myopia have a
constant significant rise in pressure compared
with their normal or hypermetropic cohorts. Two
10 year retrospective analyses of pressure record-
ings showed that the glass of myopic myopia
crystallised coincidentally with the stabilisation of
pressures in the affected eyes.8,10 This is probably
because evidence suggests that myopia distort
the soft globe of a child’s eye by simple expansive
stress and by considerably greater tangential
scleral stress, both leading to myopia.

Reduction of this pressure can be effective in
three ways: bifocals or half frames "paralyse"
accommodation, and continuous close work
then does not interfere with zonular fibre function
and ocular drainage; prisms reduce accom-
modative tensions in the medial recti and thereby
reduce globe distortion and pressure; and hard
contact lenses "reshape" any tendency to gonio-
mal obstruction11, which causes simple glaucoma of
a different type from adult glaucoma12 and malignant myopia in the
apparently normotensive eye.

Environmental and, by implication, ac-
commodative studies in isolated Japanese
islands showed 92% emmetropia and 8% myopia,
whereas on the mainland they had 50% myopia.13 These figures imply a missed
opportunity by ophthalmologists. In Bath, the
community health scheme has tackled the problem
and in a trial over five years reduced 60% of
children with severe Hypermetropia of +1.0 to
+1.0D to emmetropia using plano/bifocals with
a +1.5 addition. We can do something
about myopia, and perhaps masterly inactivity
is no longer the correct option.

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1 Perkins ES. Morbidity from myopia. Sight Sav
2 Weale R. Possible relation between refraction and
senile nictal cataract. Tr Ophthalmol Surg 1969;20:
44-5.
3 Kelly TSB. Bifocals and myopia control. The Op-
cian J 1978;8:50-5.
4 Kelly TSB. Prevention of retinal detachment by
micro lens control of myopia. Folia Ophthalmologica
Japonica 1969/20, suppl. 9.
5 Kelly TSB. Chartfield C, Edmunds J. Clinical assessment
6 Ohashi K, Young FA. Bifocal control of myopia. Am J
7 Yearout B. Development and control of myopia in
human and subhuman primates. Canad J Ophthal
8 Barqueso J, Colongo sobre myopia. Bogota. Arch
9 Tomlinson A, Phillips R. Age and axial length of
10 Jendral T, Hansson HA, Bill A. Corneodygenetsik:
Tripple perspective on glaucoma. Copenhagen: Scipio
1978.
11 Kelly TSB. Juvenile expanding glaucoma. Glaucoma
12 Yamato K. Study of visual acuity of the Yami Islanders.

Negative selection of patients for dialysis
and transplantation in the United
Kingdom
Sir,—Dr S Challah and others found that
a 29 year old patient with renal failure and
hepatitis would be allowed to die by 87% of
British nephrologists (14 April, p 1119). This
is consistent with another survey where 76%
of renal units would reject a 37 year old
patient who had hepatitis.1

Patients with renal failure and hepatitis
need a much more honest approach and open
discussion. There are at least three renal units
which will treat patients who have hepatitis
either dialysis or transplantation. With
one of these units we present a graph of five
year survival in 54 patients who were carrying
the hepatitis B surface antigen and received
grafts. The patients’ survival is well within
the normal expectation of cadaver kidney
recipients, and their hepatitis does not provide
medical grounds for exclusion from treatment.2

Nephrologists are rejecting patients because
they fear cross infection, and yet in our unit only
two members of staff have developed hepatitis
with dialysis or transplantation. From
one of these units we present a graph of five
year survival in 54 patients who were carrying
the hepatitis B surface antigen and received
grafts. The patients’ survival is well within
the normal expectation of cadaver kidney
recipients, and their hepatitis does not provide
medical grounds for exclusion from treatment.1

Staff and patients can now be given protection