reduced, or there is persistent bleeding.[1 2 4] Haemorrhoidectomy is done under general anaesthesia and may require admission to hospital.

Several operative techniques have been described.[1 2] Milligan-Morgan's open haemorrhoidectomy is most commonly used and is widely considered to be the most effective surgical technique for treating haemorrhoids.[7] Other techniques, such as Ferguson's closed haemorrhoidectomy and Parks' submucosal haemorrhoidectomy, are technically more complex.

The surgeon's choice of technique is primarily based on personal experience and technical training, and only a competently performed technique produces satisfying results.[1 4 8] If technical guidelines are rigorously followed, the feared complications associated with surgical procedures, such as anal stricture and sphincteric injuries, are largely reduced.[9] Furthermore, prophylactic metronidazole suppresses postoperative pain, increases patients' satisfaction, and allows them to return to work earlier.[6] Laser haemorrhoidectomy has no advantages over standard techniques; it is also quite expensive and no less painful.[1]

Studies suggest that stapled haemorrhoidectomy is an effective treatment, reducing postoperative pain, the length of hospital stay, and encouraging a rapid return to normal activities when compared with conventional haemorrhoidectomy.[10 11] This technique potentially provides a tool for reducing some of the complications associated with conventional surgery, provided that the operator has the technical experience. However, stapling increases operative costs; advanced surgical skills are necessary; and there is a learning curve.[12] Stapled haemorrhoidectomy may cause a full thickness excision of the rectal wall and injuries to the anal sphincter, and it does not allow for the treatment of concomitant anal disease.

Giuseppe Brisinda *surgeon*

Surgical Unit, San Salvatore Hospital, Viale G Verdi 27, 61100 Pesaro, Italy (gbrisin@tin.it)

1 Corman ML. *Colon and rectal surgery*. 4th ed. Philadelphia: Lippincott-Raven, 1998:147-205.
2 Beck DE. Hemorrhoidal disease. In: Beck DE, Wexner SD, eds. *Fundamentals of anorectal surgery*. 2nd ed. London: WB Saunders, 1998:237-53.
3 Salvati EP. Nonoperative management of hemorrhoids. *Dis Colon Rectum* 1999;42:989-93.
4 MacRae HM, McLeod RS. Comparison of hemorrhoidal treatment modalities: a meta-analysis. *Dis Colon Rectum* 1995;38:687-94.
5 Brisinda G, Maria G, Bentivoglio AR, Cassetta E, Gui D, Albanese A. A comparison of injections of botulinum toxin and topical nitroglycerin ointment for the treatment of chronic anal fissure. *N Engl J Med* 1999;341:65-9.
6 Carapeti EA, Kamm MA, McDonald PJ, Phillips RK. Double-blind randomised controlled trial of effect of metronidazole on pain after day-case haemorrhoidectomy. *Lancet* 1998;351:169-72.
7 Milligan ETC, Morgan CN, Jones LE, Officer R. Surgical anatomy of the anal canal and operative treatments of haemorrhoids. *Lancet* 1937;ii:1119-1124.
8 Brisinda G, Civello IM, Maria G. Haemorrhoidectomy: painful choice. *Lancet* 2000;355:2253.
9 Maria G, Brisinda G, Civello IM. Anoplasty for the treatment of anal stenosis. *Am J Surg* 1998;175:158-60.
10 Rowsell M, Bello M, Hemingway DM. Circumferential mucosectomy (stapled haemorrhoidectomy) versus conventional haemorrhoidectomy: randomised controlled trial. *Lancet* 2000;355:779-81.
11 Mehigan BJ, Monson JRT, Hartley JE. Stapling procedure for haemorrhoids versus Milligan-Morgan haemorrhoidectomy: randomised controlled trial. *Lancet* 2000;355:782-5.
12 Fazio VW. Early promise of stapling technique for haemorrhoidectomy. *Lancet* 2000;355:768-9.

Mental health services for people with learning disabilities

A complete overhaul is needed with strong links to mainstream services

Mental health services in the United Kingdom are set for dramatic restructuring in the light of recent government initiatives to improve quality of care and equity of provision. National standards for promoting mental health and treating mental illness are designed to reduce the risk of future tragedies and improve the quality of life of people with mental illness.[1] But little thought has been given to the well documented mental health needs of people with learning disabilities.

In the age of institutional care the disturbed and challenging behaviour of people with learning disabilities was thought to be due to their living environment and their learning disability. Their care was greatly influenced by humanistic and philosophical ideas.[2] The widespread closure of "long stay" hospitals for people with learning disabilities was accompanied by the creation of multidisciplinary community teams that tried to manage a wide range of physical and mental health needs.[3] Unfortunately, over the years, the specialist mental health provision for this group has remained fragmented, outside the mainstream mental health services, and delivered by organisations that have a poor understanding of the special needs of people with learning disabilities.[4]

BMJ 2000;321:583–4

Between 30% and 50% of people with learning disabilities may show a variety of behaviours, particularly challenging behaviour, that are precipitated by problems such as communication disabilities and physical and mental illness.[5] Challenging behaviour is a common reason why people with learning disabilities are relocated to costly residential facilities that are often far away from their families.

Mental disorders are also more prevalent in people with learning disabilities. In particular, rates of schizophrenia are three times higher than in the general population although there are few data about other types of mental illness.[2] In addition, there is evidence for a subgroup of patients with mental illness and borderline intellectual functioning who are difficult to treat in standard psychiatric services.[6] Attempts to integrate mental health provision for people with learning disabilities with generic mental health services have had only a limited impact in changing professional or service attitudes.[7]

A few joint inpatient schemes have been developed that admit people with learning disabilities who are mentally ill to adult mental health beds and provide extra support from a multidisciplinary learning disabilities team.[8] No systematic evaluation of these schemes has been carried out: anecdotal evidence

suggests that this scheme provided well for the mental health needs of people with mild learning disabilities but did not provide for those with more severe levels of cognitive impairment. This system has also been criticised because people with learning disabilities may need longer admissions, which may not be possible with the current pressure on acute psychiatric wards.[9] In the newly published national service framework for mental health there is no mention of the mental health needs of people with learning disabilities.[10]

There is generally poor provision for children and the elderly who have dual diagnoses of learning disabilities and mental illness. There is a dearth of data on service evaluation and patients' outcomes and insufficient involvement and education of service users and their carers. The continued existence of the separate system of care perpetuates the marginalisation and social exclusion of people with learning disabilities.[11]

A modern and comprehensive mental health service for people with learning disabilities and mental illness must identify the needs of this group but keep its roots within mainstream mental health services. Mental health services for people with learning disabilities need a separate or modified national framework of standards to combat the lottery that is now in operation, with some areas offering innovative services of high quality while neighbouring areas offer no service at all for similar disorders.[12]

Unless the forthcoming strategic review of services for people with learning disabilities, commissioned by the Department of Health, boldly recommends a reform of the specifications for the existing mental health services for people with learning disabilities, this vulnerable group of patients will remain out in the cold.

Angela Hassiotis *senior lecturer in learning disability psychiatry*

Department of Psychiatry and Behavioural Sciences, London W1N 8AA (a.hassiotis@ucl.ac.uk)

Phil Barron *consultant psychiatrist in learning disability*

High Wood Hospital, Brentwood, Essex CM15 9DY (Phil.Barron@bhbchc-tr.nthames.nhs.uk)

Jean O'Hara *consultant psychiatrist in learning disability*

Department of Psychiatry, Royal London Hospital, London E2 9HN

1 Department of Health. *Modern standards and service models: mental health national service frameworks*. London: Stationery Office, 1999.
2 Reid AH. Psychiatry and learning disability. *Br J Psychiatry* 1994;164:613-8.
3 Aspray TJ, Francis RM, Tyrer SP, Quilliam SJ. Patients with learning disability in the community. *BMJ* 1999;318:476-7.
4 Department of Health. *Challenging behaviours and/or mental health needs of people with learning disabilities*. London: HMSO, 1993.
5 Emerson E. *Challenging behaviour: analysis and intervention in people with learning difficulties*. Cambridge: Cambridge University Press, 1995.
6 Hassiotis A, Ukoumunne O, Tyrer P, Piachaud J, Harvey K, Gilvary C, et al. Prevalence and characteristics of patients with severe mental illness and borderline intellectual functioning. *Br J Psychiatry* 1999;175:135-40.
7 Royal College of Psychiatrists. *Meeting the mental health needs of people with learning disability*. London: Royal College of Psychiatrists, 1997.
8 Singh I, Khalid MI, Dickinson MJ. Psychiatric admission services for people with learning disability. *Psychiatr Bull* 1994;18:151-2.
9 Bouras N. Mental health and learning disabilities: planning and service developments. *Learn Disabil Rev* 1999;4:3-5.
10 Allen M, Bouras N, Holt G. *A strategy for people with learning disabilities and mental health needs and/or challenging behaviour*. London: South London and Maudsley NHS Trust, 1999.
11 Smith R. Medicine and the marginalised. *BMJ* 1999;319:1589-90.
12 NHS Executive London and Eastern Region. *Learning disabilities strategic framework: from words into action*. London: NHS Executive, 1999.

Expandable metal stents in malignant colorectal obstruction

Promising, but trials are needed on safety and cost effectiveness

There are an estimated 300 000 new cases of colorectal cancer detected in Europe and the United States each year; 7-29% of these cases present with complete or partial obstruction of the large bowel.[1 2] Patients who present with obstruction have a five year survival rate of less than 20%, a far poorer prognosis than patients who present without obstruction.[2] This poor outlook reflects not only the more advanced stage of carcinomas that cause obstruction—40% of these patients have metastatic disease at presentation—but also the greater risks associated with emergency decompressive surgery in elderly people.[3]

Despite the increasing popularity of primary resection and anastomosis, most surgeons still advocate the traditional two stage procedure which creates a temporary stoma. In patients found to have advanced disease this stoma is likely to become permanent. Only about 20% of these patients will survive for one year after this palliative surgery.[2] For patients with "curable" disease there is the option of elective re-anastomosis. Many elderly patients and their surgeons are deterred from the second closure operation because it can lead to morbidity or death; thus many patients are left with a permanent colostomy.[4]

The use of self expanding intraluminal stents is well established in the management of oesophageal and malignant biliary strictures despite the lack of evidence from randomised controlled trials. Since the first colonic stent placement was described by Dohmoto in 1991, several series have been published describing the use of the self expanding metal stent to treat malignant large bowel obstruction, either as a definitive palliative procedure or as an adjunct to allow elective surgery in patients found to have curable disease.[5] A randomised controlled trial using this technique in either of these two settings has yet to be done, and there seems to be little awareness of the technique among general surgeons, oncologists, palliative care teams, or primary care physicians.

The palliative role of this procedure particularly for patients with advanced disease deserves more attention. The use of other palliative endoscopic approaches, including balloon dilatation, the Nd:YAG laser, and injection of laureth 9 (polidocanol), are limited by complications and the need for repeated treatment. Colorectal stenting however may offer an effective, single stage alternative, thus avoiding the need for surgery.[6 7] Despite initial concerns, tumour ingrowth has only occasionally been described, but it has been successfully treated by both laser and the insertion of overlapping stents.[8 9]

BMJ 2000;321:584–5