

I was surprised to see that Mr Sherlock and others considered that none of the appendicectomies could safely have been deferred to the next day. Except for the very occasional case operated on at night for convenience, my practice is not to remove appendices during the night, and in over 400 cases I have not had cause to regret this policy. While we rightly deprecate the use of antibiotics in undiagnosed acute abdominal pain, I start treatment with metronidazole (as well as analgesia) once I have diagnosed appendicitis, and my decision to remove the appendix is not swayed by the—often dramatic—overnight response to treatment.

Most cases of intestinal obstruction and gastrointestinal bleeding, all cases of "biliary conditions," and even cases of perforated peptic ulcer may not only safely be deferred to the following day but will also benefit from overnight rehydration, correction of electrolyte imbalance, and nasogastric decompression of the gut. These measures inevitably tend to be curtailed at night when everyone wants to operate and get to bed. I consider therefore that probably only 70 (and possibly fewer) of the cases reported by Mr Sherlock and others required night time operation, which has important implications.

The reason for operating at night is the lack of money available to pay staff in busy district general hospitals to cover additional operating sessions on a regular basis for deferred emergencies. Those hospitals which run three or four "trauma lists" a week for fractured hips and deferred internal fixation of other fractures testify to the success of such a policy in freeing operating theatres at night for general surgical emergencies. With the present staffing structure of NHS hospitals, however, day time operating for all is a luxury which the NHS cannot afford; indeed, a shift system for deliberate night time emergency surgery by training surgeons desperate for experience might provide the most efficient use of operating theatres.

If, however, the proposals of the Short report are implemented, there will be no junior surgeons to operate through the night. Are consultants justified in their fears that they will end up supporting an underpriced NHS by working day and night until their retirement to keep pace with demand? I am sure that the "powers that be" would like to think they would, but I am equally certain that what would happen is that each night covered by a consultant would be followed by a vacant operating session to deal with the night's harvest of deferred emergencies. Most of the time, as my modified conclusions from the findings of Mr Sherlock and others suggest, the consultant will get a decent night's sleep and the house surgeon will get a far better grounding in the assessment of surgical emergencies than she does now, which should result in better surgically trained general practitioners. The loss of one elective operating session for each night on take would, of course, result in lengthened waiting lists, quite properly reflecting the government's reluctance to provide enough money for the NHS to function as its subscribers wish.

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SIR,—The paper on nocturnal emergency surgery has touched on all relevant factors

except one. I suspect this factor has not been mentioned as accurate statistics cannot be produced without an enormous amount of heart searching on the part of the trainee and some embarrassment on the part of the consultant. The factor is that a few surgeons in training do emergency operations which could easily wait simply because they know that if they leave these patients to be operated on next morning they will find themselves at the end of a retractor while the consultant does the operation.

The remedy is for consultants to make sure that their trainees get enough elective operating to do. They should also be prepared to come in for an emergency and take their registrar through the operation instead of "taking over" the operation themselves. Furthermore, if the registrar knows that he will be taken through a major emergency operation by a senior colleague next morning he will certainly leave patients who can wait—with benefit to the patient. Only with such a practice will the patient get the best deal and nocturnal emergency surgery be reduced.

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Treatment of oesophageal cancer: proposal for a national society

SIR,—Mr Richard Earlam's account of the management of oesophageal cancer in the North East Thames region (23 June, p 1892), though no doubt reflecting current practice, makes depressing reading from which three important conclusions are apparent. Firstly, when a major specialised operation is undertaken on an occasional basis in centres without the coordinated multidisciplinary approach of specialised units the outcome is abysmal. Secondly, the results are so different from those obtained in these units that it is clear there exist fundamental differences in philosophy, selection, and practical management of a disorder that is uncommon. Finally, data obtained either from many outdated series or even from pooled hospital activity analyses are less valid in assessing our current achievement than prospective analysis of data from specialist units.

The first objective with oesophageal cancer must be to render the patient euphagic and obviate an unpleasant death from starvation. The second is to offer a cure in selected patients. The third objective is to accomplish the above in a humane manner and with morbidity and mortality which is both clinically and ethically acceptable. The attainment of these objectives requires careful selection by a few doctors choosing the treatment without bias and after objective assessment of spread and operability. It demands a multidisciplinary approach with physicians, surgeons, radiologists, anaesthetists, radiotherapists, and oncologists employing proved advances in assessment, preoperative preparation, operative techniques, and postoperative care, together with careful documentation, follow up of patients, and continuing review of results.

The documentation and analysis of results become more meaningful if these are from a well defined catchment population as has been the experience in Lancaster. It has one of the highest incidences in the United Kingdom, and 186 patients with oesophageal carcinoma have been treated over the past 10 years. Resection has been deemed appropriate in about 40%, with a resectability rate of 95% of those operated on.¹ The procedure related mortality (hospital and 30 day

mortality) has been 10% overall, falling to 5.5% in the last two years. The mean time to death in those not surviving resection was 11.5 days; no procedure related deaths occurred after 30 days, and very few patients stayed in hospital for this length of time. Survival at one year was 5% and at five years 10%, although this latter figure is conservative as some patients remain alive two to four years after the resection. Every patient referred had fiberoptic endoscopy with a biopsy and brush cytology as an outpatient, and no one was denied a therapeutic procedure. Over 90% of those discharged from hospital who have since died have done so outside the acute hospital. Most were with their families, who were supported by general practitioners, a 24 hour district nursing service, and an oncology health visiting service.

All of these figures are very different from those of Mr Earlam's review, but are by no means confined to our own units. Very similar figures for operative mortality and survival have been published recently by Dark *et al*² and McKeown.³ We maintain that a nihilistic approach should not be adopted merely because the potential for therapeutic disaster appears to be so great. We believe that no patient should be denied the chance of a cure. Equally he should not be made to incur an unacceptable risk by being subjected to inappropriate surgical intervention; neither should a lesser procedure such as intubation be a substitute for well performed surgery on the grounds that the former carries a lesser mortality. Our experience has shown this is not the case, and resection in appropriate cases is the only treatment to achieve euphagia in over 90% of cases.⁴

What is now required is the centralisation of treatment of these patients in specialist units where a multidisciplinary approach and the concentration of numbers will allow controlled trials of the various therapeutic modalities. Furthermore, such units could through a national society for all doctors working with patients with cancer and other disorders of the oesophagus compare their results, coordinate clinical trials, and promote healthy discussion—to the ultimate benefit of the sufferers.

At the first British based international conference on disorders of the oesophagus recently held in Lancaster many specialists from various parts of the world submitted views similar to those expressed in this letter. Since then there has been a feeling among British doctors that the time has come to form such a national body. The publication of Mr Earlam's review is a timely reminder of our obligations to our patients and colleagues and we invite those interested in the concept of such a society to write to us.

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¹ Watson A. Therapeutic options and patient selection in the management of oesophageal carcinoma. In: Watson A, Celestin LR, eds. *Disorders of the oesophagus*. London: Pitman, 1984.

² Dark JS, Mousalli H, Vaughan R. Surgical treatment of carcinoma of the oesophagus. *Thorax* 1981;36: 891-5.

³ McKeown KC. Carcinoma of the oesophagus. *J R Coll Surg Edinb* 1979;24:253-74.

⁴ Watson A. A study of the quality and duration of survival following resection, endoscopic intubation and surgical intubation in oesophageal carcinoma. *Br J Surg* 1982;69:585-8.

Low osmolar contrast media

SIR,—The implication of Professor Ronald G Grainger's leading article (21 July, p 144) and letter in *Clinical Radiology*¹ is that non-ionic media should be used for all intravascular