

I did a colonoscopy; the "caecum" apparently looked normal (see below). A year later once again she was anaemic. There was no ulcer this time and a further barium enema showed an obvious caecal carcinoma which was successfully removed.

I committed two errors. Firstly, I did not consider the possibility of a second lesion seriously enough when I found the ulcer. Secondly, in retrospect, during colonoscopy when I thought I was in the caecum I was in fact in the proximal transverse colon, which commonly hangs down to the pelvis. This mistake was due to lack of experience (I had just started colonoscopy) compounded by not having x-ray screening facilities.

Case 2—A 60-year-old man with radiologically proved duodenal ulcer was recently put on cimetidine but nevertheless became anaemic. Again, there was no overt bleeding. The barium enema was unremarkable and he was therefore referred to me for colonoscopy. The first examination was unsatisfactory as there were dark liquid faeces in the proximal colon. I thought the darkness was due to iron tablets but in fact he had not taken any. On repeat examination I found lesions of the angiodysplastic type in the caecum, which I presumed were the source of his chronic blood loss.

My impression of gastrointestinal blood loss is that, in general, ulcers bleed briskly and often in bursts while proximal colonic cancers ooze occultly. Bleeding distal colonic polyps and sometimes diverticular disease are commonly mistaken for haemorrhoids when they trickle treacherously; the blood may also flow freely but unlike in ulcer disease the blood still blushes red rather than being deceptively darkened. The lesson, I think, is that the anaemic patient with a peptic ulcer who does not give a clear history of haematemesis or melaena is quite likely to have another lesion which is the source of bleeding, and requires a double-contrast barium enema, or better still pancolonoscopy.

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SIR,—The "Lesson of the Week" by Dr J W Riley and others (21 February, p 626) brings home to us how the advent of a relatively new investigation has encouraged clinicians to overlook time-honoured teaching. It is a well-known fact that anaemia is one of the classical ways of presentation of a right-sided colonic carcinoma. Patients presenting to me with symptoms from anaemia without any overt physical findings and normal sigmoidoscopy always have a barium enema as the first investigation. The article is a classical example of a delay in diagnosis because of using the wrong primary investigation, albeit a relatively recent and sophisticated one. Gastrointestinal endoscopy can, as they show, mislead and delay diagnosis of a potentially curable condition. I am sure, if endoscopy had not been available, that the patients in the case reports would have had a barium meal and follow-through (I presume so because they had an upper gastrointestinal endoscopy) and the diagnosis would almost certainly have been made much earlier.

I do appreciate that it is easy to be wise in retrospect. However, I would like to emphasise that, as an undergraduate clinical student, I was taught to ask for a barium enema as a first investigation when a middle-aged patient presented with symptoms from anaemia with stools positive for occult blood. For my part, I continue to pass on the same message as it is

still true today when gastrointestinal endoscopy is commonplace. Therefore the lesson of the week should really read, "Do not choose the wrong investigation in the form of a relatively recent sophisticated tool just because it is available."

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SIR,—I can only concur with the report and comments of Dr J W Riley and others (21 February, p 626). In my relatively short medical career I have seen four patients presenting with iron-deficiency anaemia and occult faecal blood in association with benign upper gastrointestinal pathology. Symptoms from the gastrointestinal tract were few and all were harbouring colonic carcinomas. In one patient the correct diagnosis was made at the initial presentation. The delay in diagnosis in the remaining three patients was several months. These errors in management are made all the worse when one considers the good prognosis of colonic cancers diagnosed and treated early. Chronic blood loss from the upper gastrointestinal tract, particularly in the middle aged and elderly patient, should be entertained only when the large bowel has been completely exonerated.

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Status epilepticus treated by barbiturate anaesthesia

SIR,—It is unfortunate that Dr M Partinen and his colleagues (14 February, p 520) should have chosen to quote my review¹ as an endorsement for the use of barbiturates to protect the brain stem from ischaemic damage and to lower raised intracranial pressure. The principal theme of this review was to indicate that the case in favour of barbiturates was as yet unproved, while the dangers of this treatment were definite unless continuous and intensive patient monitoring was carried out.

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¹ Miller JD. *Ann Neurol* 1979;6:189-93.

How many beds do we really need—for example, in neurosurgery?

SIR,—When discussing the variations between the provision of specialist services in different regions Dr G P A Winyard and others (7 February, 498) did not distinguish between activities that only one specialty can do and those that may be shared with others. The importance of this distinction has been discussed elsewhere.¹ No one other than a neurosurgeon is likely to clip an aneurysm or take out a cerebral tumour, and it is therefore no surprise to learn that referral rates to neurosurgeons for these conditions are similar in places with very different neurosurgical facilities. Head injury, however, comes into the second category, and yet it accounts for about four times as many neurosurgical admissions as subarachnoid haemorrhage. But there are large variations between the referral rate of head-injured patients to

neurosurgeons in different parts of Britain, as we have reported (10 January, p 101). Moreover, the present rate of referral to neurosurgical units in Britain is associated with an unacceptably high incidence of avoidable mortality and morbidity.^{2,3} If these patients are to receive adequate care by modern standards more of them need to go to neurosurgeons and sooner.

While the prospect of reducing the number of neurosurgical beds may be financially attractive, the implications for the care of head injuries could be quite disastrous. It is no surprise that the London consortium should have largely ignored this aspect of neurosurgery. But it is disappointing to find that it should have been overlooked by a team from Oxford, where head injuries used to attract more attention from neurosurgeons than elsewhere in the country.

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¹ Jennett B. *Lancet* 1979;ii:594-7.

² Jennett B, Carlin J. *Injury* 1978;10:31-9.

³ Jennett B, Murray A, Carlin J, McKean M, MacMillan R, Strang I. *Br Med J* 1979;iii:955-8.

SIR,—The article by Dr G P A Winyard and others (7 February, p 498) gives rise to great concern in respect of the figures quoted for the Mersey regional neurosurgical unit. This unit served a population of 2.93 millions¹ when cross boundary inflows and outflows are calculated—and since 1978 3.1 millions. There are 70 neurosurgical beds, including six for paediatric neurosurgery. Thus there are 21.8 adult beds per million population. The discrepancy between these figures and those quoted may well arise from the inclusion by the Oxford workers of: (1) 36 beds at Southport Promenade Hospital,¹ which though classified in the official statistics as being neurosurgical are in fact exclusively managed and used by the regional spinal injuries unit. Thus if these beds are to be included in the Mersey figures the beds in the Stoke Mandeville spinal injuries unit must be added to the Oxford neurosurgical figures. (2) Fifteen neurosurgical beds at Parkside Hospital, Macclesfield,¹ which have always been managed and used by the Manchester Royal Infirmary neurosurgical unit.

Furthermore, it is important to know when figures concerning bed availability and usage for neurosurgery are quoted whether or not the figures include those for the head injury service. In Oxford the severe head injuries are admitted into accident service beds whereas in the Mersey unit they are admitted into the general neurosurgical wards. It is also of importance when discussing neurosurgical beds to know how many medical neurological beds are available for the population. Merseyside is particularly bereft of medical neurological beds, having approximately half the figure quoted in table V (p 498) for the Oxford RHA (0.016 per 1000).

We are very concerned that such misleading figures should be published, particularly as such errors could have been avoided if the other units quoted had been consulted prior to the publication of the paper. Though we do not know the accurate figures for the other regional neurosurgical units, such as the errors in the Mersey figures that it must cast grave doubt on the validity of the whole paper. It is really not surprising that future planning