of this nature. The whole article is inclined towards conservative treatment, but there is no conservative treatment for a paraoesophageal hernia, which can present with acute symptoms of gastric obstruction.

No mention is made of anaemia, which may be a serious complication of both varieties of hiatus hernia, and while it is possible to treat this condition with continuous iron therapy, this is no guarantee against a major haematemesis—and how much better to cure the anaemia and the hernia at the same time by surgery.

Why should a patient have to suffer the inconvenience of being propped up in bed at night, not being allowed to eat what he would like to eat, and being unable to bend or stoop, and be offered surgery only when he is complaining of dysphagia due to the development of a stricture? Although it is small, there *is* an incidence of malignant change in hiatus hernia, another good reason for not persevering with conservative treatment.

The operation of abdominal fundoplication is simple and gives good results in the short term, but it has given many thoracic surgeons extremely difficult transthoracic operations when the symptoms recur. Many abdominal surgeons now appreciate that the transthoracic approach gives the best operative field for lesions of the oesophagus and gastro-oesophageal junction as, after all, nine-tenths of the oesophagus is a thoracic organ.

Perhaps the most surprising omission from your article is that no mention is made of an operation which is being performed in nearly all the thoracic surgical units in Britain, an operation which has been devised on a sound physiological and anatomical basis and gives excellent long-term results—the Belsey mark IV repair.

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[1] Baue, A E, and Belsey, R H R, *Surgery*, 1967, **62**, 396.

SIR,—In your leading article (3 December, p 1436) you advocate surgery only when conservative measures fail to control symptoms of reflux oesophagitis associated with sliding hiatus hernia and in cases with fibrous stricture. In about 10% of cases, however, a hiatus hernia cannot be demonstrated radiologically and these patients should not be denied surgery if their symptoms warrant it. Operation is also indicated in severe anaemia due to bleeding from oesophageal ulceration. In my series of 198 patients with sliding hiatus hernia severe anaemia was present in 16 (8%).[1] These patients are often treated for anaemia for years before the underlying pathology is discovered.

You discuss the currently popular Nissen's fundoplication. The author himself, however, reported[2] that 10% of his patients had postoperative difficulty in belching and suffered from gastric distension, and four died of peritonitis.

A review of hiatus hernia is incomplete without reference to Philip Allison, who was the first to describe[3] an operative method based on restoring the normal anatomical and physiological conditions, which include the subdiaphragmatic fixation of the lower oesophageal segment. This procedure does not produce additional symptoms, but its popularity has declined because of reported high recurrence rates. I have been using a modification of Allison's technique for the past 25 years. At thoracotomy the lower oesophagus is mobilised and a purse-string inserted around the sac is reduced through a small diaphragmatic incision and stitched to the undersurface of the diaphragm. A few stitches are usually added to fix the sac below the diaphragm and the limbs of the right crus are approximated behind the oesophagus.

Sumner[1] reviewed the clinical findings of 204 of my operations for hiatal hernia, 198 of which were of the sliding variety; 25 of the patients had a tight fibrous stricture preoperatively and thus presented a difficult problem. The assessment 1-10 years following surgery showed that 75·9% of patients were completely satisfied, 18·1% improved, and 5·9% dissatisfied. During this follow-up period only two of my patients required surgery for recurrent hernia.

Regardless of the method used, surgery should be undertaken only if symptoms are intractable and the patient insists on operation.

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[1] Hoffman, E, and Sumner, M C, *Thorax*, 1973, **28**, 379.
[2] Nissen, R, and Rossetti, M J, *Journal of the International College of Surgeons*, 1965, **46**, 663.
[3] Allison, P R, *Surgery, Gynecology and Obstetrics*, 1951, **92**, 419.

The cancer patient: communication and morale

SIR,—"I couldn't think what had happened to my marriage . . .". Dr T B Brewin's excellent article (24-31 December, p 1623) most sensitively setting out guidelines for maintaining communication with patients who "happen to have cancer" appears to us to call for a sequel.

The patient quoted above had spent two years wondering what was the barrier that had separated him from his wife. She knew the "full facts"; he believed his operation had been a complete success. We met him after he had finally been told of his recurrent disease by his surgeon. When asked, "Back at the beginning, would you rather your wife had been told less or that you had been told more?" he replied, "The first—but we should have been together."

We commonly meet our patients and their families at the later stages of disease. We agree with Hinton that the successful open sharing of stress can bring a special quality to marital (and other) relationships.[1] Can Dr Brewin and others give us guidance about fostering communication within the family throughout the course of this disease? Perhaps the tradition of telling the family the full facts needs to be looked at in the same sensitive way that he has described in relation to patients. Surely what so often occurs tends to separate families rather than to unite them.

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[1] Hinton, J M, personal communication, 1971.

SIR,—I have read with much interest the article by Dr Thurstan B Brewin (24-31 December, p 1623), but I am surprised and distressed that at no point in his communication with the patient or relatives does he mention the spiritual help that the patient is so often hungering for and which his parish priest or the hospital chaplain is only too anxious to give. After many years in general practice I have found that the clergy are always grateful to be told when their parishioners are in hospital. They can then communicate with the patient and the family before meeting them later at the crematorium or graveside.

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A problem with ear piercing

SIR,—With regard to the short report by Mr J Cockin and his colleagues (24-31 December, p 1631) my own experience in this field sheds further light on the matter. In response to requests from friends and nursing staff I have been using a Caflon gun, studs, and clasps for about two years. I have had no complications and the series includes two people who had had to remove their previous studs because of inflammation after insertion by a jeweller. The subjects were all people I know, so it is unlikely that complications would not have been reported. Piercing was done with proper asepsis and the studs were adjusted at the end of the procedure to ensure they were not tight and would move freely to and fro in the lobe. Success in the two repeat cases suggests that error by the operator was a more likely cause of the trouble than allergy to the 24-carat gold plating on the studs.

The manufacturers give instructions on cleaning the ear lobes and on "no-touch technique" for loading the gun, but no advice on adjusting the stud after insertion. A few problems are probably due to infection from inadequate skin cleaning or touching the stud, but most seem to be due to pressure. My gun inserts studs leaving the head proud and the clasp tightly pressed against the lobe, so that without adjustment pressure damage, swelling, and embedding would probably occur. Spontaneous rectification does not take place, because notches near the tip of the stud, for altering the position of the clasp to allow for different thicknesses of ear lobe, catch in the skin surface. It may be that other guns drive the stud too far through the lobe, leaving it too tight. One would like to know if the patients with embedded studs were initially able to move them to and fro for daily cleaning in accordance with their instruction sheet.

I do not think ear piercing with this gun needs to be discouraged, but the manufacturers should supply more precise instructions on its use to prevent complications.

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The Progestasert and ectopic pregnancy

SIR,—Dr R Snowden's observations (17 December, p 1600) are of importance to those concerned with matters of family planning. The distributors have surely acted correctly in ceasing to recommend this device until it can be accurately estimated what is the ectopic pregnancy rate for an average UK populace.

Meanwhile we suffer loss. The Progestasert did offer satisfactory contraception for a group of older women who had heavy and painful menses. If such a useful contraceptive is to be withdrawn because the ectopic pregnancy rate is 20% of pregnancies occurring, why do some