accepted that most systemic metastases are haematogenous de novo and that simpler means of locoregional control are equally successful.[3] The most effective adjuvant treatment is likely to be systemic agents such as fluorouracil and levamisole,[4] although a significant survival advantage associated with postoperative infusion of fluorouracil into the portal vein has been found, reaching a 60% reduction in the odds of death.[5] Other groups have repeated this study and confirmed the reduced mortality but found it to be of smaller magnitude; many of these studies, however, were unable to show any reduction in the incidence of hepatic metastases—presumably the improved survival arose from systemic effects of the fluorouracil.[6] The benefits of portal vein infusion are being reassessed in the axis trial of the United Kingdom Coordinating Committee for Cancer Research; the flexibility of the trial's design could perhaps accommodate a desire by the surgeon to resect small lesions before portal vein infusion.[7]

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Adenoma screening and colorectal cancer

SIR,—The central theme of the editorial by Drs Allyson M Pollock and Philip Quirke is that the value of polypectomy as a means of preventing colorectal cancer is unproved and by implication perhaps not worth while.[1] From their armchair viewpoint, however, the authors contribute little other than "knocking copy."

They challenge the "inevitability of the adenoma-carcinoma sequence," but no one has ever claimed this. Morson emphasised that only a small proportion of colorectal adenomas progress to carcinoma.[2] About 30% of the population have an adenoma by the age of 60, but the lifetime risk of colorectal cancer is only about 3%, which suggests that only 10% with adenomas develop cancer in their lifetime.

A minimum of five genetic changes are required for the formation of a colorectal cancer; fewer changes are required for the development of an adenoma.[3] Larger adenomas seem to have more genetic abnormalities, which fits with the clinical observation of their greater likelihood of containing cancer. Most adenomas are small, and it is indeed problematic to predict which could become malignant. From the observation by Muto *et al* that 40% of villous adenomas already had a focus of malignancy by the time of excision,[4] however, Drs Pollock and Quirke incorrectly conclude that the remaining 60% would never progress to cancer. They also state that "only 46% of polyps more than 2 cm will contain an invasive focus"; this figure, based on Muto *et al*'s surgical series,[4] is probably an exaggeration, but the incidence is still exceedingly high.

We do not know how to identify those adenomas that will grow, but the ease of endoscopic removal makes it unlikely that their natural course can be observed ethically as the polyp-cancer relation is widely accepted. It is, unfortunately, simplistic to call for an "urgent . . . randomised controlled trial of polypectomy" as Reasbeck has calculated that, even in high risk subjects, matched groups of 7000 patients would be needed to show a reduction in mortality from cancer.[5] Studying patients with an average risk would avoid the ethical problems of not subjecting the control group to colonoscopy, but the numbers in each group would need to be increased at least threefold (to allow for decreased compliance as well as a lower yield).

A society like ours must surely wish to identify those at risk of such a common and potentially preventable cancer, and (except for surgery in certain cases) polypectomy is currently our only weapon for reducing that risk. Epidemiologists may wish to debate available data, but surely the commonly held view that polyps present a golden opportunity to prevent cancer should remain the basis for surveillance. To denigrate colonic polypectomy in blanket fashion in a general medical journal is unreasonably nihilistic and clinically misleading.

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Pyoderma gangrenosum

SIR,—We were interested in the recent picture report of severe ulceration of the scalp.[1] Diabetes mellitus occasionally predisposes to severe skin infections, but the diagnosis of the ulceration in this case is unclear from the details given. The history of a rapidly expanding ulcer after minor trauma suggests pyoderma gangrenosum, for which paraproteinaemia is a known predisposing factor.[2] The scalp is an unusual though well recognised site for pyoderma gangrenosum, and on the basis of the dramatic photograph we suggest that this was the diagnosis. Although the prognosis in such a severe case is likely to be poor, high dose systemic corticosteroids may be of dramatic benefit.[3,4]

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Surgeons and hepatitis B

SIR,—Dr David Snashall and colleagues,[1] commenting on Mr Stuart Kennedy's personal view,[2] ask why the doctors had not been immunised. The regrettable answer must be that despite the considerable amount of information available about high infectivity of hepatitis B surgeons as a group have not appreciated the risks to which they are exposed and the protection that may be obtained by immunisation.

There has been much discussion recently within the surgical royal colleges and the surgical specialty associations about transmission of HIV during surgical procedures. With the aim of determining attitudes about testing patients and doctors for HIV the Federation of Surgical Specialty Associations—representing the 10 major specialty associations—recently sent a questionnaire to all surgeons. The opportunity was taken to ask also whether the respondent has been immunised against hepatitis B and whether he or she thinks that such immunisation should be compulsory. The fact that the question has been asked may encourage those not immunised to seek this protection. In addition, the answers should give some indication of opinion about the whole question of the risk of infection from surgical practice.

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Taxation of alcoholic beverages

SIR,—In the *Observer* colour magazine of 28 July 1991 Dr John Collee wrote about the excessive drinking of alcohol. His article included the following paragraph:

A lead article by Luisa Dillner in the British Medical Journal points out that Britain will next year be committed to harmonising its import duty with the rest of the European Community. This will result in a fall in the price of most alcoholic drinks with, we anticipate, a dramatic rise in consumption.

This would seem to be a quotation from the *BMJ* leader on alcohol abuse earlier this year[1]:

The most immediate threat to the level of alcohol consumption will come from the European Community. Britain is committed to the harmonisation of duty within the single market next year, which will mean a fall in the retail prices of most alcoholic beverages in this country. The Institute for Fiscal Studies estimates that this will result in a 46% increase in the volume of alcohol drunk in each household.

This statement needs to be corrected. Although the original 1987 proposal of the commission might have posed a threat by setting a single rate of duty for each product group, the proposal was amended in December 1989 to provide for a minimum rate of duty to take effect on 1 January 1993 and a common target rate to be achieved over a longer period.[2]

This more flexible approach strikes a better balance between the member states' interest in determining tax revenues and health policy, and the European Community's interest in securing sufficient convergence of rates to abolish fiscal frontiers by 31 December 1992. In particular, the principle of a minimum rate leaves member states free to set the duty on alcoholic beverages at levels which reflect their health concerns.

A significant step in this direction was taken on 24 June 1991 when the economics and finance ministers reached political agreement on minimum rates of excise duty for beer and wine. Those for fortified wines (sherry, port, vermouth, etc) and for spirits will be set later this year.