sentatives from manufacturers of bandages and people from within the NHS experienced in testing and evaluating these materials. Essentially the method was designed to identify the range of pressures that each class of bandage may be expected to achieve and maintain under normal conditions of use, taking account of the elastomeric properties and other characteristics of the bandage that will influence both its performance and clinical acceptability.

Contrary to the impression given by McCollum, the relation between sub-bandage pressure and limb circumference was also considered and has been discussed at length in numerous articles, one of which he referenced.[2] Wall charts and handouts describing the classification system and illustrating graphically the effect of changes in limb size on bandage pressures have been produced and widely circulated around the regions. These charts, which have been well received by medical and nursing staff, enable a practitioner to identify at a glance which of the various classes of bandages will provide the required level of compression for a leg of a specified diameter. Similarly, the drug tariff contains a simple table that relates limb circumference to sub-bandage pressure for those products recently made available on prescription that meet the performance criteria described within the test method.

McCollum, who is an enthusiastic advocate of the four layer bandage system, suggests that a multilayer bandage is safer than a single layer of a high compression bandage as errors in applying a weaker bandage would average out in multiple layers. Errors can also, however, be additive, and it could be argued that multiple layers of bandages applied with excessive tension may combine to produce unacceptably high compression in some circumstances.

The dangers associated with the incorrect selection or use of a high compression bandage have been recognised and emphasised repeatedly in the past. It is not logical, however, to criticise or ban a useful therapeutic agent simply because the possibility of misuse exists. Rather, practitioners should be carefully instructed in both the theory and practice of bandaging so that they may take full advantage of the many benefits of the sophisticated new products now available.

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Oesophageal cancer in Britain

SIR,—K K Cheng and N E Day draw attention to the disturbing increase in oesophageal cancer in the United Kingdom.[1] Because of the increasing importance of this disease, in 1990 the Medical Research Council's Cancer Therapy Committee set up a working party to conduct a programme of multicentre randomised clinical trials to investigate various aspects of treatment that seem promising in uncontrolled studies.

Intake to the first of these randomised trials has just started. The trial is based on increasing evidence from phase II studies that oesophageal cancer may respond well to cisplatin based combination chemotherapy.[2-4] It is comparing surgery with and without preoperative chemotherapy, which consists of two courses of cisplatin 80 mg/m^2 on day 1 plus fluorouracil 1 g/m^2 on days 1 to 4 (total dose 4 g/m^2) with three weeks between the courses. Cisplatin and fluorouracil are two of the most active single agents in both squamous carcinoma and adenocarcinoma and are effective in combination. It is intended to randomise 800 patients with resectable squamous carcinoma, adenocarcinoma, or undifferentiated carcinoma of the upper, middle, or lower third of the oesophagus or cardia but not patients with postcricoid tumours.

The main end point of the trial is survival, and the design is simple to encourage collaboration. Potential participants can obtain details and copies of the protocol (OE02) from D J Girling at the address below.

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Treating minor problems in accident and emergency departments

SIR,—Though I agree that patients who attend accident and emergency departments with problems better dealt with in general practice are not time wasters, I would resist any move to base general practice care in accident and emergency departments.[1]

It is often more time consuming to divert patients away from an accident and emergency department than it is to see them. Just as the development of deputising services has encouraged patients to make greater use of out of hours services and increase their expectations beyond that which many general practitioners regard as reasonable,[2] so a policy of seeing all casual attenders who present at accident and emergency departments may already have led to difficulties in providing a quality service to those with genuine acute need.

It is no surprise that patients who attend an accident and emergency department with problems suited to primary care believe that they have brought their problem to the right place, particularly if they are investigated by junior doctors using facilities available only in hospital. This department recently studied young men with problems related to injuries sustained during sport that required minimal or no treatment. Responses to a questionnaire suggested that 38% considered that they needed urgent treatment, 43% believed that their general practitioner would be unavailable, and half considered that care by their general practitioner would be inappropriate for their injury. Only a third of the patients saw coming to see a doctor as the main purpose of their visit: half stated that it was for an *x* ray examination.

Most accident and emergency departments will see patients with minor recent trauma without question, and the very title of accident and emergency suggests to the public that all injuries resulting from accidents are dealt with whether or not they constitute an emergency. Patients with non-traumatic musculoskeletal pain often present as emergencies. The dividing line between primary care in general practice and in accident and emergency departments is blurred in this and many other examples. Cooperation between consultants in accident and emergency and general practitioners in defining locally acceptable practice and exploiting opportunities to educate those patients misusing the service will ultimately lead to improvements for patients and doctors alike. If doctors find it difficult to define what is appropriate will it not confuse the public further if accident and emergency departments and out of hours general practice services are in the same place?

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Contraception for the under 16s

SIR,—Victoria Gillick implies that those who provide contraceptive advice and services to the young are not concerned with the sexual behaviour and reproductive health of teenage girls.[1]

As one who provides such services I say that we are very concerned indeed and endeavour to see that young people do not suffer, both in terms of unwanted pregnancies and sexually transmitted diseases and, more broadly, in their personal and sexual relationships. The vast majority are already sexually active when they consult us and often present at their first visit for emergency contraception or because they are worried that they are already pregnant.

We all deplore many things that we see around us, and teenage sex (particularly among those who are under age) may be one of them. By all means, Mrs Gillick, alter society so that these things do not occur, but until you reach that goal please encourage us in our work of trying to minimise the undesirable consequences of sexual activity among young teenagers.

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MRC's association with Sugar Bureau

SIR,—We were concerned to learn that the Medical Research Council is organising a workshop on dental caries in association with the Sugar Bureau.

The aim of the Sugar Bureau is to promote the products of the sugar industry and thus has nothing to do with an independent organisation financing and deciding on priorities in scientific research. As the Committee on the Medical Aspects of Food Policy recently concluded that the evidence incriminating sugar in the aetiology of caries indicates that consumption of sugar should be reduced to no more than 10% of total dietary energy[1] it is not surprising that the Sugar Bureau is willing to provide the resources. But is the Medical Research Council so short of funds that it is willing to be associated with any organisation? Will it next be cosponsoring a workshop with the tobacco industry on the aetiology of lung cancer, or with the Dairy Council on the causes of heart disease? Will its next collaboration in this field be with the Cocoa, Chocolate and Confectionery Alliance?

We have no idea who chose the speakers for this conference and have no quarrel with the list of speakers, for they are all recognised authorities in the subject. Nevertheless, we think that it is naive of the Medical Research Council to imagine