and not infrequently malignant changes, unfortunately so common in Britain, are extraordinarily rare.

Are hereditary, climatic, or even skin pigmentation factors involved? Despite its radiological and histological identification, is the disease process one and the same thing in different racial groups or in different places? Surely an international demographical survey is needed. It well may indicate the aetiological factor or factors in a disease which remains "of cause unknown" and which has been shown to be as prevalent and serious in Britain and elsewhere as it is strangely rare in many parts of Africa.

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Diet and coronary heart disease

SIR,—I am grateful for Dr V M Hawthorne's reply (16 July, p 186) to my intentionally challenging letter (4 June, p 1467). He confirms my view that many epidemiologists, ignoring evidence from clinical and laboratory investigators, wish through the media to persuade the public to change their diet.

Epidemiological evidence is by definition restricted, and statistical correlations are not necessarily causal. Any view of coronary disease which is based on one type of study and which omits appreciation of the whole collateral range of meticulous research is incomplete and therefore biased.

The speculation that elevated blood lipids cause atheroma is now regarded as untenable by many distinguished investigators of long experience in this field.[1] Thus informed modern medical opinion is swinging away from the lipid hypothesis of causation and is unlikely, on present evidence, to condone the imposition on the public of any major change in the nature of the fats they consume.

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[1] McMichael, J, *European Journal of Cardiology*. In press.

Abdominal wound dehiscence

SIR,—A number of letters and articles have recently appeared in your and other journals on the subject of the cause of the "burst abdomen." For some inexplicable reason most authors seem deliberately to avoid the all-important factor—the nature of the incision which caused the burst abdomen.

I think everyone now accepts the evidence that transverse and oblique abdominal incisions heal better than vertical ones, and yet vertical incisions are still persistently used in operations that could just as easily be performed through incisions that are so much less likely to cause subsequent trouble. I recently reviewed a series of 400 cholecystectomies that had been performed on my unit. An oblique subcostal incision had been used routinely. There was one burst abdomen, which followed a very extensive haematoma of the abdominal wall, and this patient subsequently developed an incisional hernia. The only other burst abdomen, also followed by an incisional hernia, occurred in a patient in whom a perforated gall bladder was removed through a paramedian incision as a result of a faulty preoperative diagnosis. If only vertical incisions were avoided whenever possible I am quite sure that the incidence of both wound dehiscence and incisional hernia would almost disappear, regardless of the type of suture material employed.

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How dangerous is obesity?

SIR,—Dr John Womersley draws attention (9 July, p 119) to the confusion which exists about the effects of obesity on health. Lack of exercise is accepted as an adverse factor in relation to coronary heart disease, and it is perhaps logical to consider obesity in relation to exercise.

The person who is mildly overweight will continue his normal way of life, expending more energy in the process; a further degree of obesity will slow him down. Thus a man who is 2 stones (13 kg) over Metropolitan Life Insurance Company ideal weight will probably still walk to work and climb the stairs when he gets there. In doing so he is exercising more vigorously than the man of "ideal" weight. When he reaches 4 stones (25 kg) above ideal weight he will be more likely to ride to work and to use the lift when he gets there. Thus the conclusion reached by the Chicago People's Gas Company Study[1] that "moderate overweight appears to be a sign of good health" is not surprising.

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[1] Dyer, A R, *et al*, *Journal of Chronic Diseases*, 1975, **28**, 109.

Campylobacter enteritis

SIR,—Dr M B Skirrow has reported the possible importance of campylobacters as a cause of enteritis (2 July, p 9). During a three-month period from the end of March 1977 we have examined 338 faecal specimens for campylobacters using the methods described by Dr Skirrow. Of these, 182 were from cases of sporadic diarrhoea, 60 from persons being screened prior to work in the food industry, 31 from convalescent carriers of intestinal pathogens, and 65 for whom no clinical details were available. The results are shown in the accompanying table.

The campylobacter isolates were kindly examined by Dr Skirrow and found to conform to the group *C jejuni/C coli*. Two-thirds of the isolates were from patients in the age range 15-44 years and the sex ratio was approximately equal.

These results, obtained from an urban area in the north-west of England, appear to confirm Dr Skirrow's observations that campylobacter is a common cause of sporadic diarrhoea in the community.

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Management of the elderly agitated demented patient

SIR,—I would like to communicate some preliminary observations on the use of haloperidol in the management of the elderly agitated demented patient. Such patients present as sudden crises in the community and are a relatively common cause for the general practitioner requesting a domiciliary visit by a consultant psychiatrist. Often the picture is that of an elderly relative who, despite some years of dementia, has been tolerated quite happily at home but suddenly becomes an impossible burden owing to the onset of extreme agitation. The latter, which may be due to a small but important cerebral infarct, means that the relative begins wandering during the day, often dangerously into the street, and becomes very noisy and restless at night. The emotional burden on the family is sudden and intense and there is often considerable embarrassment with the neighbours. Sometimes the general practitioner has tried phenothiazines or benzodiazepine tranquillisers without success, and it is most important to prove to the family that the difficult behaviour *can* be controlled rapidly and effectively, as the demand for admission to a non-existent psychogeriatric bed is intense and angry from the family.

Haloperidol in doses of 10 mg thrice daily and 30 mg at night to start with is quite safe in the old and often physically infirm. It has negligible effects upon the cardiovascular system and respiration,[1] often a major hazard with phenothiazines.[2] Furthermore, an analysis of such cases seen over the past two years suggests that demented patients show very much less Parkinsonian side effects than are seen in other subjects. Anti-Parkinsonian agents were rarely necessary at all, which is particularly important as the elderly seem prone to develop confusion with these drugs. A theoretical reason for this may well be the fact that recently it has been demonstrated that there is a significant reduction of choline acetylase in the neostriatum in senile dementia. This is a specific loss of cholinergic activity which is normally under tonic inhibition by

Pathogens isolated from 338 faecal specimens

Category of specimen	No of specimens	Pathogens isolated	No	%
Sporadic cases of diarrhoea	182	*Salmonella* sp	1	0·5
		Shigella sp	2	1·1
		Enteropathogenic *Escherichia coli*	1	0·5
		Giardia	5	2·7
		Campylobacter	14	7·6
Healthy asymptomatic (screening)	60	Campylobacter	1	0·2
Convalescent carrier	31	*Salmonella* sp	16	51·0
		Enteropathogenic *E coli*	1	3·2
No clinical information available	65	*Salmonella* sp	2	3·9
		Shigella sp	3	4·6