SIR,—S Y Chuah and colleagues conclude that patients sedated with intravenous midazolam tolerate upper gastrointestinal endoscopy without needing topical anaesthesia.[1]

Since 1986 we have performed upper gastrointestinal endoscopy in government hospitals in Malawi. All patients receive an explanation of the procedure just before the endoscopy, and then a topical anaesthetic (10% lignocaine spray) is applied to the pharynx. We do not use intravenous sedation; reasons include the expense, shortage of space and of trained staff to supervise patients after the procedure, and patients' convenience and safety (many come on foot as outpatients and need to return to their homes straight after the investigation). Compliance during endoscopy is usually excellent, and we rarely have procedural failures.

Lignocaine spray is not on the World Health Organisation's essential drug list for Malawi, and we have to rely on our own personal purchases or special orders, which may take a long time. If doctors decide to heed the advice of Chuah and colleagues and abandon the use of topical anaesthesia we would be grateful if they could consider sending us their spare bottles of lignocaine spray.

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Treating carcinoma of the oesophagus

SIR,—When commenting on the treatment of carcinoma of the oesophagus Minerva[1] misrepresents an excellent article by Bown on managing carcinoma of the oesophagus with palliative intent.[2] Considering that it was produced by one of the world's experts on one particular palliative measure, this article presents an extremely balanced view of all modalities and the need for further study. Bown did not discuss the role of surgery and certainly did not make any comment about its futility. Minerva has fallen into the trap of expressing a personal conviction that was not mentioned by the author. She is right in saying that most patients with carcinoma of the oesophagus should be treated palliatively, but her comment is misleading.

We reported a study in which we elected to operate with curative intent on 35% of patients presenting at the Royal Devon and Exeter Hospital with oesophageal cancer from 1985 to 1987.[3] As the geriatric population is higher than average in our district other units might well consider that figure to be low. During the study 116 out of 125 patients were discharged from hospital able to swallow. The mortality in patients with localised disease who received palliative treatment was 3%; mortality for the operation was 7%; and the mortality in patients with distant metastases who received palliative treatment was just over 10%. There was nothing futile about our inclusion of surgery as one of the modalities in our management protocol.

We are currently collating our figures for the past four years, which we expect will be even better. Thanks to the improvements in anaesthesia and postoperative intensive care only one surgical patient has died during this period.

Many years ago Earlham and Cunha-Melo painted a gloomy picture of carcinoma of the oesophagus.[4] Sadly, their paper continues to be quoted frequently and has become dogma. Minerva's comments add further to this misconception. It is important that practitioners should know that a considerable number of their patients would be thought worthy of an attempt at curative surgery and that in units specialising in this form of surgery the mortality is extremely low. The five year survival may be only around 20%, but those who are not cured receive good palliative treatment and usually live longer than patients who are intubated or have brachytherapy or laser treatment.

Far from being futile, surgery has much to offer, and I recommend that practitioners should refer their patients to a surgeon with an interest in this disease, who will know better than anybody the risks of operation and, when operation is contraindicated, will be better informed about the most suitable palliative option. I have several patients who are well who, had they been treated with Minerva's philosophy, would have been long dead.

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Adenoma screening and colorectal cancer

SIR,—C B Williams and colleagues are in danger of allowing professional interests to cloud the issues.[1] Our editorial stated that there is uncertainty as to the effectiveness of the current practice of polypectomy in the prevention of colorectal cancer.[2] This is no armchair exercise, nor a debate of the relative merits of available data, but an illustration of the difficulties in achieving clinical consensus in the absence of good epidemiological studies.

The issue for clinicians, since most adenomas never progress to cancer, is, what should the policy be? We make two recommendations. We suggest that in the absence of other clinical guidelines, the King's Fund statement on colorectal cancer is a good place to start.[3] We also state that there must be further research into developing better predictors of risk than those currently available (size, histology, and degree of dysplasia). This should include a randomised controlled trial of polypectomy, which is a common procedure but has never been shown to be effective in preventing colorectal cancer.

It is regrettable that Williams *et al* consider that such a common procedure as polypectomy should be exempt from a clinical trial on the grounds that the number of patients required for such a trial are too large. Are they not aware that there is currently a very large trial in colorectal cancer of faecal occult blood testing which involves over 156 000 participants?[4] The estimate of 7000-21 000 patients (depending on risk category) required for a randomised control trial of polypectomy appears trifling in comparison. Moreover, given the high prevalence of polyps in the population and the large numbers of people undergoing polypectomy annually, is it ethical not to mount a randomised control trial of an unproved intervention, which carries with it significant risks of morbidity and mortality? In 1987 over 42 000 colonoscopies were performed in England and Wales.[5] The average cost of a colonoscopy is £107-£250.[6] Surely patients have the right to know what procedures are effective in reducing the risk of colorectal cancer?

Until a national research strategy ensures that researchers seriously address these issues, which must include examining the efficacy of what clinicians do, then the case for adenoma screening and polypectomy still remains unproved.

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Orthopaedic surgeons and thromboprophylaxis

SIR,—The survey by M D Laverick and colleagues[1] confirms the statement of Michael J F Fordyce and colleagues[2] that, despite the many regimens described, there is no consensus on the most suitable prophylaxis for preventing deep venous thrombosis after total hip replacement.

In Ireland, as in Britain, most orthopaedic surgeons have avoided using heparin because of the perceived risks of bleeding complications. Some have used dextran 70, although there are no published reports of a significant benefit for dextran 70 over placebo.[3]

Excellent results, with rates of deep vein thrombosis of around 13%, have been reported by workers using adjusted doses of subcutaneous heparin.[4] Unfortunately, the necessity for close monitoring and adjustment of the dose means that this method can be successful only when there is a high degree of commitment and laboratory facilities are available seven days a week.

Recently, several low molecular weight heparinoids have become available. The results obtained by P F Leyvraz and colleagues in their comparison of adjusted dose heparin with fraxiparine provide further evidence that these agents may finally produce a consensus among orthopaedic surgeons as to which regimen is best for prophylaxis.[5]

Another low molecular weight heparin, enoxaparin, became available in Ireland late last year. The manufacturer's datasheet indicates that it can be given in a fixed dose once daily for prophylaxis against deep vein thrombosis after surgery, including joint replacement surgery.[3] Because the drug is expensive there were considerable financial implications if it was to be adopted for thromboprophylaxis in elective joint replacement surgery. After extensive review of published reports the Drugs and Therapeutics Committee added enoxaparin to the formulary. It is now used by all orthopaedic surgeons performing total knee and total hip replacement in the hospital. Enoxaparin was added to the formulary because of the evidence that its use could reduce the rate of thrombosis to 10% or less without an unacceptable risk of bleeding complications.[6,7]

Consensus was reached with the hospital anaesthetists that the first dose of enoxaparin would be given 12 hours before surgery. The pharmacokinetics of enoxaparin suggest that epidural anaesthesia is safe when the first dose is given this way.[8] This was supported by interim, unpublished results of a large multicentre trial (Rhone Poulenc-Rorer, personal communication, 1990)—an important factor for anaesthetists,