Letters and Comment

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. Tables and figures should be included only if absolutely essential and no more than five references should be given. The Editor reserves the right to subedit contributions to ensure clarity

The surgery of mitral stenosis 1898–1948: why did it take 50 years to establish mitral valvotomy?

I read with great interest the recent article by Treasure and Hollman (*Annals*, March 1995, vol 77, p145) on the history of the surgical treatment of mitral stenosis. Unfortunately, they gave the wrong dates for the first successful surgical treatment of mitral stenosis by Bailey and Harken. Instead of 5 June 1948 and 9 June 1948 that were cited in the article, Bailey did his first successful mitral commissurotomy on 10 June 1948 *(1)* and Harken followed with his successful mitral valvuloplasty on 16 June 1948 *(2)*, as I discussed in my recent book on percutaneous balloon valvuloplasty *(3)*.

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References

1 Bailey CP. The surgical treatment of mitral stenosis (mitral commissurotomy). *Dis Chest* 1949; **15:** 377–97.
2 Harken DE, Ellis LB, Ware PF, Norman LR. The surgical treatment of mitral stenosis. I. Valvuloplasty. *N Engl J Med* 1948; **239:** 801–9.
3 Cheng TO. *Percutaneous Balloon Valvuloplasty*. New York/Tokyo: Igaku-Shoin, 1992.

Peptic ulcers can now be cured without operation

We read with interest the recent article by Dr J H Baron (*Annals*, May 1995, vol 77, p168) suggesting that the ideal method of detecting *Helicobacter pylori* is the carbon-labelled urea breath test using ^{14}C or ^{13}C. Although the ^{13}C urea breath test is practical, non-radioactive and non-invasive to the patient, reports have shown false-positive results *(1,2)*. This may be owing to the presence of *H. pylori* in other parts of the gastrointestinal tract.

We agree with the author that antral biopsies with histology does not exclude *H. pylori* infection in the body when the result of endoscopy is negative. The presence of *H. pylori* has been shown to be present in the oral cavity by various methods, for instance bacteriological culture using selective medium *(3)* and polymerase chain reaction *(4)*. Other urease-producing bacteria, for instance *Actinomyces viscosus* and *Streptococcus vestibularis*, found in the oral cavity *(5)* can also rapidly degrade urea-forming ammonia and carbon dioxide. It is therefore likely that the oral *H. pylori* and other urease-producing bacteria may be responsible for the false-positive results of the ^{13}C urea breath test. We are investigating the feasibility of the urea breath test in detecting oral *H. pylori*.

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References

1 Logan RPH, Polson RJ, Misiewicz JJ *et al.* Simplified single sample ^{13}C urea breath test for *Helicobacter pylori*: comparison with histology, culture and ELISA serology. *J Br Soc Gastroenterol* 1991; **32:** 1461–4.
2 Johnston BJ, Celestin LR, Reitmayer R *et al.* *^{13}C urea breath test as a practical test to monitor Helicobacter pylori status. VII. Workshop on Gastroduodenal Pathology and Helicobacter pylori.* Houston Texas, 1994.
3 Cheng LHH, Webberley M, Evans M *et al.* *Helicobacter pylori* in dental plaque and gastric mucosa. *Br J Oral Maxillofac Surg* 1993, **31:** 258–9.
4 Mapstone NP, Lynch DAF, Lewis FA *et al.* Identification of *Helicobacter pylori* DNA in the mouths and stomachs of patients with gastritis using PCR. *J Clin Pathol* 1993; **46:** 540–3.
5 Marsh P, Martin M. *Oral Microbiology*, 2nd Edition. London: Chapman & Hall, pp 92, 207.

Use of split-skin grafting in the treatment of chronic leg ulcers

Skin grafting for ulcers caused by arterial disease certainly is a difficult area, and we would concur with Wood and Davies (*Annals*, May 1995, vol 77, p222) that results are often disappointing. However, their outcomes for arterial ulcers are somewhat difficult to interpret in the face of such small numbers and in the absence of any information of Doppler pressure measurements.

Collaboration between plastic surgeon and vascular surgeons is fundamental in these cases. After arterial reconstruction ulcers may heal spontaneously, or if they are large, skin grafts may then take well. A short delay between revascularisation and the skin grafting is often helpful to maximise the chance of success.

In our experience pain is the primary indication for attempts at skin grafting in this difficult patient group. If skin cover can be achieved then pain is relieved. For patients with intolerable discomfort an aggressive approach to revascularisation and skin grafting seems worthwhile.

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We read with interest the recent article by Ward and Davies (*Annals*, May 1995, vol 77, p222). They describe their experience with the use of split-skin grafts in a variety of patients ($n = 26$). With relatively small numbers, subsequent subgroup analysis can be unreliable and hence it is difficult to be sure if those patients with arterial ulcers