

SHORT REPORTS

Safe limits of drinking: patients' views

The agreed recommendations for safe limits of alcohol consumption from the Royal Colleges of Psychiatrists, General Practitioners, and Physicians¹⁻³ are less than 14 units a week for women and less than 21 units a week for men. If these guidelines are to be used by primary health care workers to promote healthy lifestyles, they must be accepted by patients.

The results of a survey three years ago showed that there was little consensus among a sample of experts on the effects of alcohol about the safe limits of alcohol consumption.⁴ A similar study among general practitioners showed that they gave lower limits of alcohol consumption than the experts.⁵ The present study was designed to ascertain what limits of alcohol consumption were considered safe by patients attending their general practitioners.

Subjects, methods, and results

Nine practices were selected, five in London and four in Oxfordshire. Each practice was given 100 questionnaires and asked to arrange for them to be completed by all patients attending for consultation on one week day. The patients were asked to complete the questionnaire while waiting to see the doctors and to hand the completed questionnaire to them. Each patient's alcohol consumption was assessed by a quantity/frequency question with one unit being equivalent to one half pint of beer, one glass of wine or sherry, or a single measure of spirits. Drinking was classified as light (0-10 units/week), moderate (11-35), or heavy (≥ 36). The questionnaire included the question: "In your opinion what is a reasonable or sensible limit that men and women should place on the amount they drink each day if they are to avoid damaging their health?" Patients were asked to give separate answers for subjects who drank only beer, lager, or cider (pints/day); only wine, sherry, or vermouth (glasses/day); and only spirits (single measures/day). Separate answers were sought for men and women. Statistical analysis was by the unpaired Student's *t* test.

Altogether 561 questionnaires were completed, 298 in London and 263 in Oxfordshire. There were 187 men and 374 women; around a third were under 35, a third between 35 and 54, and the remainder over 55 years of age. Nearly half the patients thought that two to four units a day were safe. The table summarises the results. For all drinks men gave higher limits of alcohol consumption than women. Heavy drinkers gave higher limits than light drinkers and, with the exception of beer, patients in London gave higher limits than patients in Oxfordshire.

Comment

The study population was not a random sample but comprised patients attending general practices. Recognising, however, that most preventive care in general practice is undertaken when the opportunity arises, we considered that it was legitimate to study this group of patients. Higher safe limits of alcohol consumption were given for beer than for wines or spirits by both men and women. This may reflect a lack of knowledge of the equivalent alcohol contents of different drinks rather than a belief that beer is safer than wine or spirits. Except for beer, the safe limits given by most patients were well within those recommended by the colleges.

Our results suggest that the safe limits of alcohol consumption recommended by the colleges are generally accepted by patients. Primary care staff should be encouraged to assess each patient's alcohol consumption and if it is above the recommended safe limit advise its reduction.

We thank the nine general practices for helping with the distribution and collection of the questionnaires and Jackie Hodgkinson for typing the manuscript.

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Regression of rectal adenomas after colectomy and ileorectal anastomosis for familial adenomatous polyposis

Total colectomy and ileorectal anastomosis for familial adenomatous polyposis has been the procedure of choice for many years in Britain. It is recommended that patients are examined after operation by sigmoidoscopy every three months and that rectal adenomas are fulgurated when necessary. This policy of regular follow up has led to the suggestion, based on subjective clinical impressions of individual cases, that adenomas in the retained rectum may regress after surgery.¹⁻³

The aim of this study was to document prospectively, as accurately as possible, any change in the numbers of rectal adenomas after colectomy.

Patients, methods, and results

Eighteen consecutive patients who had familial adenomatous polyposis and underwent total colectomy and ileorectal anastomosis by one surgeon between 1980 and 1984 were studied. The colon was fully mobilised and the bowel clamped at a distance of 15 cm from the anal verge as measured by sigmoidoscopy during the operation. The rectum was washed out, and adenomas in the rectum below the clamp were counted. A sigmoidoscope was inserted to the level of the clamp and then withdrawn by intervals of 1 cm, recording the number of adenomas in each interval until the dentate line was reached. The quadrant (posterior, right, anterior, or left) occupied by the adenoma and the approximate size (<5 cm, <1 cm, or <1.5 cm) were noted and recorded.

A second count was performed in the outpatient department during sigmoidoscopy. After a phosphate enema the site of ileorectal anastomosis was identified and the count performed exactly as during the operation. This examination occurred at a median of 10 months (range eight to 32 months) after surgery and in 14 of the 18 cases was carried out by the same person who performed the count during the operation. Wilcoxon's paired rank test was used in statistical analysis of the data.

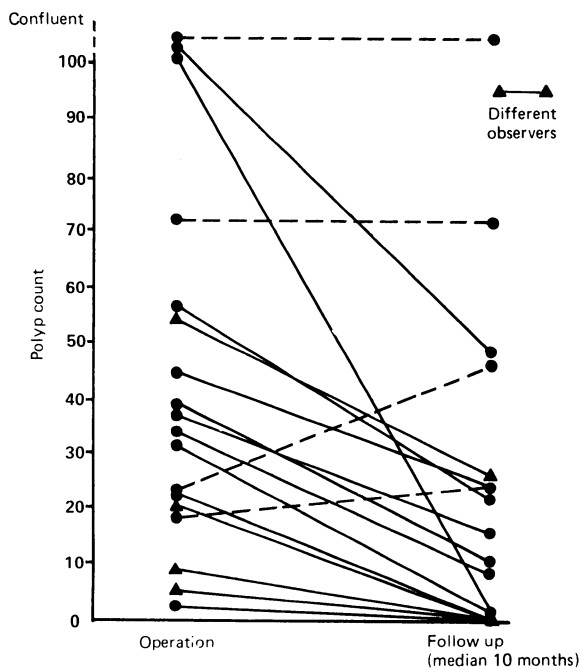
The figure shows the numbers of adenomas seen during and after surgery. In

Mean (SEM) safe alcohol consumption given for women and men (units/day) by category of respondent

Category of respondent	Safe No of units for women			Safe No of units for men		
	Beer	Wine	Spirits	Beer	Wine	Spirits
Sex of respondent:						
Men	3.91 (0.19)***	2.47 (0.10)***	2.13 (0.12)***	4.89 (0.22)**	2.83 (0.12)***	2.48 (0.13)***
Women	3.01 (0.01)	1.83 (0.06)	1.49 (0.05)	4.17 (0.15)	2.30 (0.08)	1.92 (0.08)
Consumption category of respondent:						
Light	3.07 (0.09)***	1.88 (0.05)***	1.52 (0.05)***	3.98 (0.12)***	2.26 (0.06)***	1.89 (0.06)***
Moderate	3.85 (0.24)	2.50 (0.14)	2.43 (0.16)	5.37 (0.25)	3.11 (0.16)	2.98 (0.16)
Heavy	5.00 (0.72)	2.84 (0.25)	2.69 (0.50)	7.22 (0.71)	3.46 (0.46)	3.50 (0.56)
Location of respondent:						
Oxford	3.00 (0.12)**	1.82 (0.07)***	1.50 (0.07)***	4.00 (0.16)	2.18 (0.10)	2.28 (0.09)***
London	3.47 (0.13)	2.14 (0.07)	1.85 (0.07)	4.55 (0.15)	2.60 (0.08)	1.88 (0.08)

For men compared with women, light drinkers with heavy drinkers, and patients in Oxford with those in London, ** $p < 0.01$ and *** $p < 0.001$ respectively.

patients who had more than 100 polyps areas of apparent confluence were encountered, which made accurate counting above this figure impossible. There was an increase in two patients and no change in another two. In the remaining 14 there was a decrease from a median of 50 (range 2-100) to 22 (range 0-50). Overall the change between the counts during the operation and those after was significant ($p=0.002$). There was no relation between the size of the decrease and the duration of the interval between counts.



Polyp counts during operation and at follow up.

Comment

Bussey *et al* have studied the reliability of polyp counting with particular reference to the variation between two observers.¹ They reported counts by different observers to vary by not more than 27%. In the present study a standardised technique and, in most cases, the same observer were used to minimise even this variation. Allowing for a 30% error in the number of polyps recorded for any pair of observations, the counts obtained in our patients still show a significant decrease.

Many factors have been suggested to account for the regression of polyps. They include a decrease in the pH of the faecal stream, a reduced rectal blood supply, and the removal of a colonic "stimulating factor." The relation between regression and the development of carcinoma is interesting. It cannot be said that an absence of rectal polyps provides complete protection against carcinogenesis. Several cases of carcinoma in patients who do not have polyps have been recorded.² The question of whether repeated trauma from fulguration or biopsy may be a precipitating factor has been raised. Cancer of the rectum has not been seen in patients who undergo spontaneous regression.³ Some patients who undergo regression subsequently develop further adenomas, mainly at the site of anastomosis. Regression of polyps does not reduce the necessity for a policy of intensive surveillance.

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Skin fragility and blistering due to use of sunbeds

We describe six patients in whom prolonged use of sunbeds resulted in skin fragility.

Case histories

Six patients presented with increased fragility of the skin and formation of blisters in response to minimal trauma. All were unable to obtain more than a minimal tan in natural sunlight because of their tendency to burn and had used ultraviolet A sunbeds for prolonged periods (table).

Use of sunbeds by patients with increased skin fragility

Case No	Age (years)	Sex	Duration of use (years)	No of sessions/week (duration of each session in minutes)	Estimated cumulative exposure to ultraviolet A (kJ/cm ²)*
1	24	F	3	4 (30)	28
2	21	F	4	5 (60)	77
3	28	F	6	2 (60)	30
4	17	F	1	2 (60)	9
5	18	F	2	4 (30)	19
6	37	M	2	7 (30)	33

*At presentation all patients were using lamps with an output of 0.1 kJ/cm²/h, but some had previously used lamps with lower outputs.

All of the patients were mildly tanned at presentation. The skin on the dorsum of the hands appeared thickened and inelastic. Clear and blood filled blisters had arisen on non-inflamed skin on the dorsum of the hands and feet and on the shins in each patient. Hyperpigmented scars and milia formed when these blisters healed. General examination was normal in all cases. Three patients were taking an oral contraceptive, one sometimes took tablets of frusemide because of ankle swelling, and two were not taking any drugs.

Porphyria analysis (porphyria service, Western Infirmary, Glasgow) of blood, urine, and faeces yielded normal results in each case. Histological examination of skin biopsy specimens from four patients showed subepidermal blisters associated with minimal infiltration of the dermis by inflammatory cells. Basement membrane positive for periodic acid Schiff was prominent around dermal blood vessels. Electron microscopy showed separation in the superficial collagen beneath the basal lamina. Specimens from two patients were examined by direct immunofluorescence and showed dense deposition of IgG and C3 along the zone of the epidermal basement membrane and around the blood vessels. Several months after their last exposure on a sunbed four patients were phototested with an irradiation monochromator at 300 nm (ultraviolet B) and 350 nm (ultraviolet A). Erythematous responses 24 hours later were within the normal range. Three to six months after the patients abandoned the use of sunbeds some lessening of skin fragility had occurred.

Comment

Though the clinical features were similar to those of porphyria cutanea tarda, this disease was excluded by the normal results in porphyria analysis. The relevance of the various drugs taken by some of the patients is not known, but the normal results of phototests in four patients do not support a drug induced phototoxic response. The mechanism of cutaneous damage by ultraviolet A irradiation is not known, but the level in the skin at which blister formation occurred and the results of direct immunofluorescence are similar to those in epidermolysis bullosa acquisita,^{1,2} which is thought to be immunologically mediated. Skin fragility after use of a sunbed has been reported previously, but the level of blister formation was not described.³

At the time of presentation all of the patients owned solarium (sunbed plus sun canopy) that incorporated fluorescent ultraviolet-A lamps. Our patients' estimated cumulative whole body exposure to ultraviolet A from using a sunbed (9-77 kJ/cm²) is greatly in excess of the exposure of an indoor worker in the United Kingdom (estimated to be 1 kJ/cm²/year).⁴ One week of sunbathing at a latitude of 40°N would result in a maximum dose of ultraviolet A of around 0.3 kJ/cm². Despite the massive exposures each patient achieved only a minimal tan. This contrasts with people who tan easily in natural sunlight, who can achieve a moderate tan in 10-20 half hour sessions on a sunbed (a cumulative exposure to ultraviolet A of 0.5-1.0 kJ/cm²).

Although skin may become more fragile in only a few people who use ultraviolet A sunbeds, people who tan poorly in sunlight or require large doses of ultraviolet A to achieve a tan should be discouraged from using these sunbeds.

We thank our colleagues for referring these patients and Dr G Bird for performing the direct immunofluorescence.