Correspondence

Action on Smoking and Health

Sir,—The second report of the Royal College of Physicians—Smoking and Health Now—once more gives clear evidence of the disastrous health consequences of cigarette smoking for the people of this country. The first report resulted in a temporary reduction of cigarette smoking. The College is determined to do all it can to effect a permanent reduction in what is acknowledged to be the major environmental health hazard today.

It has therefore decided to sponsor Action on Smoking and Health (A.S.H.). A.S.H. is planned as an independent national organization with a small but active full-time staff. It will straddle many professions and walks of public life and its aims will be:

1. To provide information on smoking for the benefit of the health of the community at large.
2. To stimulate and support research into the problems of smoking and health,
3. To consult regularly with other bodies actively concerned with the smoking problem to strengthen and harmonize their efforts,
4. To influence public opinion—forming bodies who are at present uninformd and unconcerned,
5. To act as an authoritative voice speaking for all individuals and organizations seeking to influence public and private attitudes towards smoking.

The solution of the smoking problem will require a long-term effort, and A.S.H. will need to be securely based and be able to function effectively over a number of years. A.S.H. will be launched at the Royal College of Physicians on 20 January and a number of representative organizations and individuals are being invited.

In the past many doctors have felt frustrated at their inability to speak up and take action on the problem of cigarette smoking. The founding of A.S.H. now provides an opportunity for the profession to take a lead and it is hoped that organizations and individuals who accept its aims will join A.S.H. in concerted action. Further particulars can be obtained from: The acting General Secretary, Action on Smoking and Health, The Royal College of Physicians, 11 St. Andrew's Place, Regent's Park, London N.W.1—We are, etc.

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1 Royal College of Physicians of London, Smoking and Health Now, London, Pitman, 1971.

Restless Legs

Sir,—Hardly anyone will dissent from the propositions in your leading article (26 December, p. 758) that most patients with "restless legs" show no signs "either of systemic disease or psychoneurosis," and that many of them "become obsessed with the severity of their symptoms." However, every disabling syndrome having a chronic, fluctuating course is regarded as a nervous manifestation of invalidism until its true pathology is discovered. History of medicine abounds with such examples. At present we are still in the taxonomic stage as far as "restless legs" are concerned, and this calls for strict accuracy in the terminology used. It is of some consequence, therefore, that in the two articles on restless legs (26 December, pp. 774 and 796) the term "nocturnal" myoclonus is used in different connotations. Dr. J. D. Spillane noted (26 December, p. 796) that "nocturnal myoclonus may of course be the present complaint unassociated with restless legs," an observation which his Case 2 illustrates abundantly.

To overcome the ambiguity of "restless legs unassociated with restless legs" it seems to me necessary to accept "nocturnal" myoclonus as a variant of the syndrome of restless legs. Several other variants can also be recognized, for example, pain and myoclonus group; pain group; and "sleep" pain group.

The restless legs group represents, of course, by far the commonest variant; it is also associated with nocturnal myoclonus, as the spouse of the victim will readily confirm. The term restless legs by being descriptive is also restrictive and cannot without confusion be applied to most of the variants mentioned, especially since the arms may be affected—a clinical feature which did not escape Thomas Willis. A more comprehensive nomenclature is therefore, required, and I suggested the term "dyslysis" because the disorder is one attendant upon relaxation of the limbs. In the light of present-day neurophysiological concepts it can be claimed that relaxation of the limbs is as much a "positive" phenomenon as is the motor counterpart. The disorder of the mechanism whereby relaxation of the limbs is attained is probably in most cases genetically determined, as is suggested by the frequent incidence of this condition among several members of one family. Such predisposition frequently remains latent and becomes overt as a result of the influence of a great many different factors—for example,

Intermittent Drug Regimens for Pulmonary Tuberculosis

D. H. Shennan, M.D.

National Morbidity Survey

D. L. Cramble, M.B.

Self-certification?

G. C. Greig, M.B.; J. L. Kearns, M.B., D.I.H.

Prescription Charges

J. J. Segal, M.B.

Big Brother's Scrutiny

M. Robinson and T. Pendry; K. S. Zin-

mann, F.R.C.PATH.

Accident and Emergency Services

D. Lamont, F.R.C.S.Ed.; F. C. Durbin,

F.R.C.S.

Salmon and Cowgill

B. J. Bickford, F.R.C.S.
anaemia, various unrelated painful conditions of the lower limbs, chronic pulmonary diseases (Dr. Spillane's cases), uraemia, 1 3 gastric surgery, and diabetes mellitus. 4 The following case illustrates the adverse influence of pregnancy. During the later stages of each of her four pregnancies this patient experienced frequently recurring "heavy attacks" which, as Dr. Spillane says, can be of "tormenting nature." I am, etc.,

SIMON BEHRMAN

London W.1.

1 Behrman, S., British Medical Journal, 1958, 1, 21
2 Willis, T., quoted by Baarini, N. K., and Hur- witz, L. J., British Medical Journal, 1970, 4, 774.
3 Coelho, N., Neurology (Minneapolis), 1966, 18, 359.
4 Baarini, N. K., and Hurwitz, L. J., British Medical Journal, 1970, 4, 774.

Medical Management of Rheumatoid Arthritis

Sir,—Dr. R. Bluestone's article on the medical management of rheumatoid arthritis (5 December, p. 602) prompts us to take issue with him on several points. We feel well qualified to offer an alternative view because we spend a good deal of time trying to salvage something from the wreckage of joints which orthodox laissez-faire treatment too often leaves behind.

It is futile to treat severe progressive disease with weak, so-called anti-inflammation agents, with seropositive analgesics. We believe it is wrong to follow the usual sequential method in such cases, since by the time the physician has applied various drugs in turn and found them inadequate irreversible damage has been done to the joints. All too often the space of 18 months witnesses the change from normality to crippling. Perhaps 10% of painful and seropositive arthritides are in this category. The time is short; their urgent need is for treatment which will be effective with the least possible delay. Aspirin in full dosage, phenylbutazone, indomethacin, and other analgesics are worse than useless in this situation; they ensure only a more comfortable ride to destruction. Only steroids can influence the disease quickly enough to affect the outcome, and the early addition of immunosuppressives may often be advisable.

The use of intra-articular injections of steroids into weight-bearing joints in ambulant patients is often unhelpful if the disease in general is active, and it may increase the risk of joint damage by removing the protection of pain. To describe this as the most useful role of steroids in rheumatoid disease is short sighted.

The side effects of corticosteroid treatment in small to moderate dosage are less to be feared than the side effects of unstrained disease; except for pituitary-adrenal inhibition most can be controlled by strict joint destruction to become evident. The toxic effects of chloroquine are less frequently disastrous than Dr. Bluestone thinks, provided that the dosage is moderate and the treatment intermittent. There is evidence that retinal damage may be prevented by protection from ultraviolet light (a minor problem in this country). Moreover, the published reports of controlled trials have not advocated high-dose chloroquine therapy. We agree that gold is often useful and effective, but Dr. Bluestone should remember the limitations as well as the advantages of chrysotherapy; these were clearly defined in the report on the Empire Rheumatism Council trial, 1 which showed that, in common with antimalarials, gold (under the conditions of the trial) did not influence progression of erosions seen radiologically.

It is crucial that patients should be stratified according to their individual prognoses at an early stage and that appropriate treatment should be given without waiting for gross joint destruction to become evident. It is also desirable that the policy for each patient should be reviewed at regular intervals and that a policy which is failing should be changed.—We are, etc.,

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1 Empire Rheumatism Council Annals of the Rheumatic Diseases, 1961, 20, 315.

Selective Vagotomy without Drainage

Sir,—Fifteen months ago I reported the early results of bilateral selective vagotomy without drainage (20 September, 1969, p. 690). The omission of any drainage operation is based on the hypothesis that if truncal vagotomy made a drainage operation obligatory bilateral selective vagotomy, by preserving innervation of the pylorus and duodenal bulb, might allow good gastric emptying without any drainage procedure. A special food-barium meal was used to study gastric emptying, a film being taken at nine hours and the degree of retention expressed by the size of the barium residue, which varied from 0 to +++. (see 1969 paper). When the special meal was given to 15 "normal" people 13 were graded 0 and two graded++. The results obtained in 1969 in 17 patients after vagotomy and a single layer Heineke-Mikulicz pyloroplasty are shown in Table I.

| Months after operation | 1 | 3 | 6 | 9 | 12 | 18 | 24 | 27 |
|------------------------|---|---|---|---|----|----|----|----|
| 1                      | + | + | + | + | +  | +  | +  | +  |
| 3                      | + | + | + | + | +  | +  | +  | +  |
| 6                      | + | + | + | + | +  | +  | +  | +  |
| 9                      | + | + | + | + | +  | +  | +  | +  |
| 12                     | + | + | + | + | +  | +  | +  | +  |
| 18                     | + | + | + | + | +  | +  | +  | +  |
| 24                     | + | + | + | + | +  | +  | +  | +  |
| 27                     | + | + | + | + | +  | +  | +  | +  |

Twenty unselected patients have now been examined one year after bilateral selective vagotomy without drainage. Care was taken to exclude any patients for this operation in whom any degree of organic duodenal narrowing was present. The results (Table II) show that one year after bilateral selective vagotomy without drainage in patients with duodenal ulceration but without organic stenosis gastric emptying is virtually normal. Indeed the stomach empties better without drainage than it does with pyloroplasty. The drainage operation should wherever possible be omitted for there is wide agreement that most of the sequence of sequelae of vagotomy and drainage are due to the pyloroplasty or gastro-jejunostomy and not to the vagotomy itself.

Some 120 patients have now been treated in this way since April 1967. Not one case has developed lesser curve gastric ulceration. Our studies suggest that when selective vagotomy is useful without drainage care must be taken to exclude organic narrowing for mucosal stenosis may be more severe than the muscular narrowing of the duodenum suggests. In some cases the duodenum must be dissected free from adhesions before the muscular narrowing can be seen.

The pyloric branches of the hepatic pleura supply, as Lalatree showed, the pylorus and the duodenal bulb and probably too a very small amount of prepyloric stomach. He stated that the nerves, which we now know by his name, do not reach the pylorus and this fact can be clearly demonstrated in man at operation. Previously, therefore, the immediate prepyloric stomach is supplied by the pyloric branches from the hepatic pleura. These pyloric branches may be easily stimulated in man. Care must be taken to see that no anti-cholinergic drugs have been previously given. The pylorus and duodenal bulb are seen to contract when the stimulus is applied. If a clamp is placed across the duodenum beyond the bulb, the motor function of these pyloric branches may be demonstrated by a rise in intragastric pressure on stimulation. It seems that bilateral selective vagotomy without drainage is an important step in the evolution of vagotomy. It should encourage us to operate before organic narrowing has occurred.

We now await with interest the later results of highly selective vagotomy without drainage. 1, 2 This important modification is yet another step forward in vagotomy. Already we may claim almost without doubt that highly selective vagotomy without drainage is not followed by recurrent duodenal ulceration nor by gastric ulceration

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1. Behrman, S., British Medical Journal, 1958, 1, 21.
2. Willis, T., quoted by Baarini, N. K., and Hurwitz, L. J., British Medical Journal, 1970, 4, 774.
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1. empire Rheumatism Council Annals of the Rheumatic Diseases, 1961, 20, 315.