Harrison has highlighted the sharing of medical knowledge and therapeutic techniques between indigenous and British medical men. Sharing was no doubt present but the rate and intensity varied over time. As the colonizing state entrenched itself, it could by its own volition rupture the channels of sharing and could place the universalist claim of western medicine more persuasively and pervasively. For instance, the nature and dialogue between Indian and European medical traditions were not the same in the eighteenth and nineteenth centuries. When the Britishers were seeking a foothold and groping in the dark, initiation of this dialogue on their part was necessary and it 'jelled' well with their larger orientalist endeavour, but as political hegemony was established, this dialogue became feeble. On the shared basis of colonial knowledge, despite the mass of contrary evidence he himself presents, Harrison argues that the term orientalism is unable to encapsulate the complexities of ideas and knowledge generated in the medical discourse in tropical colonies. Extending his argument about European indigenous medical knowledge, he perceives problems not in the conceptualization of colonial science in general and colonial medicine in particular, but medical historians who have used this conceptual tool to claim very different assumptions. They have used it for the Victorian age (latter half of the nineteenth century), whereas Harrison has consciously projected it back to the eighteenth century and conveniently proved the unworthiness of this conceptual tool.

Harrison's narrative strategy is mesmerizing and elegant. It also has the capacity to gloss over the methodological weaknesses present due to the use of Eurocentric and metropolitan sources, where 'native' opinion has no place. Yet, precisely for this reason, the book deserves a serious reading.

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Post-gastric surgery: Is a closer follow up required?

There is now overwhelming evidence that gastroduodenal surgery for benign conditions confers an increased risk of gastric stump carcinoma after a period of 20 years or more. Stael von Holstein summarised 13 studies that followed cohorts who were operated between 1956 and 1995. These cohorts had previous partial gastric resection or gastrojejunal anastomosis and vagotomy. Six of these studies had shown significantly higher standardized mortality ratios from death due to gastric cancer. Safatle-Riberio et al.'s review of the risk of gastric stump cancer includes 10 studies where the risk could be estimated. More than 20 years post-surgery, the relative risk was 2 or more. With time, at 40 to 45 years post-surgery, it was 7.3. A meta-analysis of studies that followed up distal partial gastrectomy with Billroth II gastrojejunosotmy showed a relative risk (RR) of 1.6 (95% CI: 1.15–2.18) of developing stomach cancer with Billroth I gastrectomy, a RR of 1.2 (95% CI: 1.01–1.42).3

Interestingly, the risk for the post ‘vagotomy with drainage procedure’ stomach is different. Watt et al.4 investigated such patients and found a median interval between ulcer surgery and death due to gastric cancer to be only 13 years. A Canadian study showed that the mean interval between vagotomy and pyloroplasty and subsequent gastric cancer was only 12.5 years after excluding gastro-oesophageal cancers in both groups.5

The most common operation performed in India for ulcer is vagotomy with a drainage procedure. A large number of these operations have been performed in the past few decades on relatively young patients. This would mean that there is a large population of post ‘vagotomy with drainage procedure’ patients in India who are at risk for developing gastric cancer. With the advent of H, antagonists, proton pump inhibitors and the discovery of Helicobacter pylori, there has been a drastic reduction in the number of such operations being performed. In our hospital, over a 17-year period (1980–1997), 10.8 patients per 10 000 admissions underwent gastrojejunosotmy with vagotomy. This had reduced to 5 per 10 000 admissions in 1998–99, presumably due to improvements in the medical management of these conditions. The numbers at risk would, therefore, decline over the next few decades.

The prognosis of post-gastrojejunostomy–vagotomy carcinoma/stump carcinoma depends on the stage at diagnosis. Resectability and survival depend on the stage of the tumour; stage I having a better 5-year survival (74.4%) than stages II (33.3%) and III (22.3%). Stage IV had no survivors at 5 years. It is thus important that in order to have a curative resection, screening with upper gastrointestinal endoscopy should be repeated at periodic intervals in those who have had a gastrectomy or gastrojejunosotmy at least 10 years after surgery. Those with dysplasia on endoscopic biopsy will require a closer follow up. However, multiple biopsies would be needed, not only from the anastomotic area, but also from other sites in the remnant/stomach.

We, especially gastroenterologists and surgeons, have an advocacy role as individuals (professionals), medical institutions/hospitals, societies or associations in this matter. It is incumbent on us to call back all patients who have had such procedures in the past few decades for regular endoscopy. Well thought out messages in appropriate languages should target those at risk individually, or through the mass media. Adequate counselling facilities, endoscopy and histopathology services will be required to meet the demand that could be expected. Long term follow up plans should be in place. Professional bodies should produce guidelines for performing endoscopy, biopsy, histopathology and surgery, including minimum standards and quality issues that should be the subject of internal, professionally led, audits.

In the next two decades, we would perhaps see the last of these carcinomas disappear, if the medical management of peptic ulcers does not have any long term consequences like its surgical counter-
part. However, for the significant number of patients at risk now, periodic endoscopic screening and early surgery offer the best hope for cure.

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A practical method of disposing sharps in India

Recommendations to prevent transmission of blood-borne pathogens to health care workers include measures to prevent injury due to sharp items used on patients.\(^1\) In addition to meticulous handling of sharps during procedures, there should be provision for their safe disposal after use. The Centers for Disease Control, Atlanta, recommends that used sharps be disposed of in puncture-resistant containers, placed close to the areas where the sharps are generated.

The biomedical waste management rules, framed by the Ministry of Environment and Forests, Government of India, state that each health care facility should have an efficient system for segregation of sharps and final disposal of sharps.\(^2\) The directive is to use 1% hypochlorite solution or some other chemical to disinfect the sharps, and then mutilate them to prevent unauthorized reuse. Besides this, there are other methods of collecting and destroying needles, each having its inherent advantages and disadvantages. We feel that the method we use at the Christian Medical College Hospital, Vellore for handling sharps will be suitable for other centres in India as well.

The important steps for any waste disposal system, including that of sharps, are collection, transportation, temporary storage and final disposal.

containers are placed on the treatment tray and carried to the patient’s bedside while bigger containers are placed in treatment rooms and nursing stations.

The containers are kept locked at all times. After use, needles are disposed of directly into the larger container through the circular opening in the lid. When the container is nearly full, it is transported by the ward attendant to an area for temporary storage. No handler comes in contact with the sharps at any stage of disposal and hence is not exposed to injury or infection.

Disinfectants are not used in the collection containers for the following reasons. To ensure efficacy, the disinfectant has to be replaced periodically, usually daily. This, in addition to the logistic problem, also poses a hazard to the personnel changing the disinfectant. If standards for disinfection are not practised, disinfection will be inadequate and the sharps may be handled without adequate care. Also, most chemicals corrode metal and some types of plastic. This can cause leakage and possible injury and infection.

For temporary storage, two big drums are kept in a fenced enclosure within the hospital premises. The door to this enclosure is kept locked, but there is a small window above the drums, through which the containers of sharps from the wards are emptied by inverting them onto the drums with their lids open. The storage area can be modified or omitted, depending on local needs. For example, a brick-walled enclosure can be used or the sharps can be subjected to final disposal by mutilation on a daily basis. When the drums are nearly full, the contents can be subjected to autoclaving or incineration as recommended in the directive.\(^2\)

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