appropriately, tests of memory can serve as useful detectors of awareness. However, their disadvantage is that they are retrospective in nature and can be of no assistance to the anaesthetist—or patient—at the moment awareness occurs. As Breckenridge and Aitkenhead suggest, a more profitable direction for research may therefore be the use of sensory evoked potentials which provide an index of the anaesthetic depth and can detect changes in state at the moment they occur.

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References

1 Millar K, Watkinson N. Recognition of words presented during general anaesthesia. Ergonomics 1983;in press.
2 Jones DM, Jones MEL, Lewis MJ, Spriggs TLB. Drugs and human memory: effects of low doses of nitrazepam and hyoscine on retention. Br J Clin Pharmacol 1979;7:479–83.
3 Desai N, Taylor-Davies A, Barnett DB. The effects of diazepam and oxprenolol on short-term memory in individuals of high and low state anxiety. Br J Clin Pharmacol 1983;15:197–202.
4 File SE, Lister RG. Do lorazepam-induced deficits in learning result from impaired rehearsal, reduced motivation or increased sedation? Br J Clin Pharmacol 1982;14:545–50.

A common bile duct sound: an aid to sphincterotomy

I agree with Mr Laurence Tinckler (Annals, March 1983, vol. 65, p. 119) that location of the common bile duct opening into the duodenum can be facilitated by passage of a suitable bougie. When I assisted Mr John Hosford at Bart's in 1946 I was taught to use a silk-web bougie for this purpose. Such a firm but flexible instrument readily adapts itself to the contours of the duct without risk of damage to soft tissues which can be engendered by use of metal bougies or probes. The tip of a silk-web bougie is readily felt as it projects through the ampulla into the lumen of the duodenum. Moreover, if transduodenal choledochotomy should prove necessary, the incision in the duodenum can be precisely located and the lower end of the common duct is readily opened up by incising the ampulla onto the emerging bougie.

The surgeon has a wide choice of silk-web bougie sizes available but one of between 14 and 16F is generally most suitable. I have used this technique for the last 37 years and far prefer it to the use of a more rigid metal instrument. It also has the virtue of cheapness and of dispensing with the need for additional special instruments.

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I was interested to read the description of an aid to duodenal sphincterotomy by Mr L F Tinckler (Annals, March 1983, vol. 65, p. 119).

In this article he states 'Apparently unimpeded passage of a bougie or sound down the common bile duct into the duodenum does not necessarily mean that the instrument has passed through the sphincter of Oddi into the duodenal lumen as it may have merely pushed the papilla ahead of it, giving a spurious impression that drainage of the bile duct contents into the duodenum is assured'.

Many years ago I found that if a shiny metal bougie was used and its distal end was pressed against the inside of the duodenal wall one could see a 'glint of steel' if the light was well directed onto the duodenal area if the end of the bougie was in the duodenal lumen but there was no such glint if the bougie was covered by the duodenal papilla.

I have used this 'glint of steel' sign ever since and have found it always reliable. I do not know if other surgeons are aware of this useful sign and I am, therefore, writing to mention it.

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Stripping branchial fistulae

Mr J H Neame (Annals, March 1983, vol. 65, p. 123) advocates 'stripping' of branchial fistulae. He also refers to the technique of the late Mr Alan Small which has certainly proved most satisfactory in the hands of a number of surgeons. I have used Small's method; indeed, I persuaded him to publish it in greater detail in 1960 *(1)* after it had already been referred to in a surgical textbook in 1958 *(2)*.

Mr Neame states that Small used a 'catheter' but does not specify that this was a fine ureteric catheter which is gently passed into the fistula with or without the wire stiffener *in situ*. Having inserted the ureteric catheter through the external opening the dissection is then done through a skin crease incision situated roughly midway between the clavicle and mastoid process. The track of the fistula is clearly visualised from its external opening to the wall of the pharynx.

In view of the close relationship of a branchial fistula to the hypoglossal nerve as well as the divisions and branches of the carotid artery I believe that many surgeons would hesitate to use a 'blind' procedure. I wonder if Mr Neame could let us know how often he and others have used his operation.

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References

1 Small A, Lancet 1960,ii,891–2.
2 Basic Surgery, Ed. Leslie Oliver, London: HK Lewis 1958, p. 866–7.

Mr Neame replies as follows:

With reference to Sir Reginald's letter, I am interested to hear that the idea of putting a catheter up the branchial fistula had been often used, a fact of which I was unaware. I do not suppose it makes much difference what one uses in fact and I am sure a ureteric catheter would work well for stripping as well as a guide.

I have only used stripping twice which is why I suggested that more experience of the technique is necessary but the fistulous tract inverted so easily that I feel it is safe. Presumably if there had been a lot of infection and fibrosis, it might be less advisable.

Bleeding and cupping

I was very interested in the article on bleeding and cupping by Mr J L Turk and Elizabeth Allen (Annals, March 1983, vol. 65, p. 128) in which they say that these techniques lapsed in the nineteenth century.

Wet cupping is certainly practised at the present time in West Africa, using multiple scarification with a simple sharp instrument, and then the distal end of an animal's horn from which the tip has been removed in order to allow evacuation by oral suction. Nearly all patients presenting with orthopaedic type pain will have had scarification and cupping of this type before they attend, and occasionally resulting local skin sepsis can delay more modern operative techniques.

It is not uncommon to see patients by the roadside with one or more horns attached to their torsos.

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