Mention is made on several occasions in the paper of the smooth folds of mucous membrane seen on cystoscopy. It is this appearance and the absence of any trabeculation at all that distinguish the condition from an obstructive bladder. This appearance of enormous smooth folds of bladder wall is, we feel, the most important way of diagnosing the condition. Partial cystectomy is a procedure that on mechanical grounds should improve the condition; and, although, as I pointed out, the residual urine may increase after operation, it is unlikely the bladder will dilate enormously again. One would expect the atony and fibrous-tissue formation in the bladder wall to be self-limiting.

Surely the absence of trabeculation of the bladder wall, the absence of distension of kidney, pelvis, and ureters, the normal blood urea, the absence of obstructive urinary symptoms, the normal appearance of the bladder neck, and the typical histology of the resected bladder wall in these cases point to the condition being one of primary atony. A similar condition is not infrequently seen in the colon where atony occurs in later life, and at laparotomy for symptoms of chronic intestinal obstruction no organic obstructing lesion is found.—I am, etc.,

North Staffordshire Royal Infirmary, Stoke-on-Trent. H. S. TRAFFORD.

Unilateral Amblyopia

SIR,—Although Mr. R. B. Wellesley Cole (*Journal*, January 24, p. 202) is to be congratulated on drawing the attention of the medical profession to the importance of diagnosing and treating unilateral "suppression amblyopia" at the earliest possible age, I think he should have mentioned that: (*a*) some degree of amblyopia may be present in a patient with normal binocular single vision. Such amblyopia is usually associated with anisometropia and may gradually lessen if corrective spectacles are worn constantly (often without any occlusion); (*b*) slight amblyopia for distance vision may be associated with normal near vision; and (*c*) an apparently "useless" (or "grossly defective") eye with regard to *visual acuity* may be of great value from the point of view of *visual field*.

I would agree with Mr. Wellesley Cole that amblyopia should be tackled in earliest infancy, although I think many people will find it difficult (in the absence of strabismus) to believe that "it is possible to diagnose amblyopia even in the youngest baby." Certain signs, however, may lead one to suspect an amblyopic eye in an infant, especially if there is a positive family history.

I should like to know what Mr. Wellesley Cole means by his statement that "a baby is wall-eyed." Such a colloquialism is likely to be misleading, and one can only assume that he means to imply what Chavasse did by stating that "all infants are born with bilateral amblyopia" and that the development of the function of the fovea is largely a matter of the development of a conditional reflex.

Few ophthalmologists will agree that refraction in a child is better done without a cycloplegic, although careful preliminary examination before prescribing atropine is most important. Although it may be difficult to insist that a routine ophthalmic examination should be made when a child is, say, 2 or 3 years old, in order that the early diagnosis of amblyopia and strabismus can be made and their treatment undertaken, yet it is surely not too much to hope that all infants born of squinting or amblyopic parents, or in whose families such conditions are known to exist, should be so examined. If this were done and early treatment instituted the percentage of persons with amblyopic eyes would, I think, be substantially reduced.

Finally, Mr. Wellesley Cole has omitted to mention the valuable work of Cüppers in connexion with the after-image method of treatment, especially in cases of eccentric fixation. By this method many cases of severe amblyopia have been considerably improved at the age of 6 to 8 years.—I am, etc.,

London, W.1. T. KEITH LYLE.

Surgical Rehabilitation of Delinquents

SIR,—My appreciation of the very interesting and modestly stated paper by Dr. D. A. Ogden (*Journal*, February 14, p. 432) was marred only by one vital omission. He reports that 30 (54.5%) of 55 treated cases were free of reconviction in the two years after their release, whereas the corresponding figure for untreated cases was 34.5%. Unfortunately he does not inform us *how many* untreated cases there were, so that the significance of the difference in these percentages cannot be assessed. It would add greatly to the value of his paper if this one item of information could be given.—I am, etc.,

London, S.E.5. G. M. CARSTAIRS.

SIR,—The article by Dr. D. A. Ogden (*Journal*, February 14, p. 432) was both interesting and stimulating, but perhaps some comment should be made before any conclusions be drawn. As a statement of clinical impression the article is beyond cavil, but as a piece of valuable research it cannot be considered satisfactory as presented and, probably, therefore, not of methodologically sound construction. I would note one or two points.

Firstly, Dr. Ogden invites us to compare quite different groups; differing at least in the presence of some remedial physical disability. One would like to know how the two groups compared from a psychiatric, a social, and a criminological standpoint. For example, a young criminal who has a squint that has become a focus "of resentment" is more likely to be diagnosed as having an anxiety or neurotic state rather than as a psychopathic personality. This latter nosological category, with a generally accepted poor immediate prognosis, might well have been over-represented in the group not in receipt of surgical treatment.

Secondly, even if the two groups were matched the results of the investigation remain suspect in that, apart from the remedial surgery performed, the investigated group were in receipt of considerable additional attention—not inappropriately termed supportive or non-specific psychotherapy. Surely Dr. Ogden has become involved with a number of variables that are now inextricably confused in his research.

A piece of work that is methodologically acceptable, that takes into account all the important variables, is not easy to set up, particularly in a busy Borstal institution. Nevertheless, it is of importance that profound conclusions are not drawn from inadequate work that lacks the necessary degree of methodological sophistication: conclusions such as "it (remedial surgery) renders the individual susceptible to the normal character training processes." I would emphasize that these criticisms are not motivated by any hostile attitude toward the conclusion drawn by Dr. Ogden, on the contrary I would endorse them from my own clinical impression and find them in accord with

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