travenous pyelography and micturition cystography. It is now our routine to wait until the patient has had a course of drug therapy and treatment with the alarm bell before arranging radiological investigations." They do not make other reference to "drug therapy," but 33% of their enuretic children were not cured by the electric alarm. They seem therefore to imply that a sizable proportion (? 33%) of enuretic children (ages unspecified) will require investigation by intravenous pyelography and voiding cystography. With this conclusion I must disagree.

Recognition of the very small minority of cases where enuresis is the symptom of an organic disease can be done by simple attention to a few salient points: (1) Excluding infection by examining the urine. (2) Excluding outflow tract obstruction and neurogenic bladder by checking the normality of the urinary stream and the absence of palpable bladder after voiding. (3) A careful history—for instance, periods of constant leaking of urine in a girl suggest an ectopic ureter.

Apart from the obvious undesirability of any non-essential pelvic radiology in children, past experience suggests that elaborate radiological investigations in enuretics are apt to prove positively misleading. For instance, no fewer than 61 of 135 (45%) enuretic children investigated by Fisher and Forsythe[1] by means of voiding cystography were considered to have "abnormalities of the urinary tract." Since all agree that the vast majority of enuretic children, whether treated or not, eventually lose the symptom, one is bound to conclude that the numerous radiological "abnormalities" which may be picked up will turn out to be no more than a large shoal of very red herrings.—I am, etc.,

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REFERENCE
1 Fisher, O. D. and Forsythe, W. I., 1954, *Archives of Disease in Childhood*, 1954, **29**, 460.

Mentally Subnormal Children

SIR,—Your leading article, Mentally Subnormal Children (17 January p. 130), brings out many of the problems that may arise following the transfer of responsibility for teaching the subnormal. The need for special teachers prepared to involve themselves with all subjects has been recognized by the National Society for Mentally Handicapped Children, which aims to establish a training school for teachers of the subnormal.

However, though some parents may feel their children would benefit from a more educational approach, thinking parents are much more concerned with the attitudes of staff to children. It is not so much a question of whether a particular child would benefit from academic education but of whether it is worth finding out. All too often doctors, social workers, and teachers make dogmatic assumptions that a child with such and such syndrome can under no circumstances have more than a fixed level of ability. Assumptions of this type have their basis in statistics derived from children who have vegetated in hospitals. There are no worthwhile statistics based on children who have been trained to the full extent of their capacity, so few have received such training.

Much more important than any change of departmental responsibility is an end to the present rigidity of mind among professional personnel. Since we have the initial responsibility it is for the medical profession to give a lead and admit that we cannot forecast except in the broadest terms what the ultimate attainment of any particular infant will be. If doctors spoke more of what will be possible and less of what will not, others might be encouraged to lift their sights higher.—I am, etc.,

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Transmission of Toxoplasmosis

SIR,—Your leading article on transmission of toxoplasmosis (17 January, p. 126) pays attention to the great discovery by Dr. W. M. Hutchison and his colleagues (p. 142). The last sentence of it asks, however, for some comment. It is stated that *Isospora hominis* is a rare human form of coccidiosis. If you mean the disease is rare, I agree, but if you mean the presence of sporocysts in the faeces then I would like to point out that we have examined 1, 820 newly joined Army recruits; 8% of these boys were found to be infected.[1]—I am, etc.,

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REFERENCE
1 Manschot, P. B., Sleegers, Th. M., and Meuwissen, J. H. E. T., *Nederlandsch Tijdschrift voor Geneeskunde*, 1968, **112**, 2038.

Diverticular Disease of Colon

SIR,—The recent article on the natural history of diverticular disease (13 December, p. 639) is welcome because it represents one of the largest series yet reported on this very common but poorly studied condition. Much of the voluminous literature on this subject is of little value because of the confusion engendered by the acceptance of assumptions long passed down through the literature without subjection to critical analysis.

The most misleading instance is where bowel symptoms present in patients found to have diverticula are assumed to be due to the diverticular disease. In a condition whose incidence approaches 50% of patients over the age of 50 years[1] it is essential that a control group also be studied. While there is sound evidence that diverticular disease is casually related to perforation and pericolic abscess, at present evidence is lacking that other symptoms, such as recurrent left iliac fossa pain and altered bowel habit, occur more frequently in patients with diverticular disease than in those with macroscopically normal colons. In fact, work in progress in this department suggests that the opposite is true.[2] These symptoms frequently persist after resection, particularly if they were present before surgery.[3] In this case the natural history of the disease can be validly assessed only in terms of conditions which are clearly related to the diverticular disease, such as proved inflammation, obstruction, and fistula.

A second assumption is that radiology is an accurate method of assessing the incidence and extent of the disease and its complications. Because of the capricious manner in which barium given by enema fills diverticula, this examination generally underestimates the incidence of the condition and may give a misleading picture of the extent of diverticula. Combined radiological and pathological studies[4 5] have shown that most of the signs usually regarded as indicating diverticulitis are not related to the presence of inflammatory disease.

A further misleading assumption is that surgical resection is a wholly successful method of treatment for diverticular disease, and that increased resort to "prophylactic" resection in relatively early cases can be justified. The results of Mr. Parks's investigation (Table VII) confirm those of many other studies that there is a remarkably small difference in the long-term results of groups treated conservatively or by surgery—particularly in relation to persistence of mild symptoms. Thus, although clinical experience shows that surgical excision is an effective and gratifying measure for patients with severe complicated disease, widespread application of "prophylactic" surgery for early disease will confer little benefit on the individual patient.—I am, etc.,

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2 Hughes, L. E., *In Proceedings of the 3rd Asian-Pacific Congress of Gastroenterology*, 1968, **3**, 6.
3 Bolt, D. E., and Hughes, L. E., *British Medical Journal*, 1966, **1**, 1205.
4 Williams, I., *British Journal of Radiology*, 1963, **36**, 393.
5 Fleischner, F. G., Ming, S. C., and Henken, E. M., *Radiology*, 1964, **83**, 859.

Long-term Use of Depot Tetracosactrin

SIR,—Drs. B. L. J. Treadwell and P. M. Dennis (20 December, p. 720) referring to depot tetracosactrin (Synacthen) end with the comment that "its obliterative effect on the diurnal rhythm of cortisol production is a theoretical disadvantage in long-term therapy."

To date we have studied four patients who have been treated with 0·5 mg. depot tetracosactrin twice weekly for prolonged periods. It was found in all of these patients that after one year of treatment the plasma corticosteroid levels, measured by the Mattingly method,[1] showed a definite 24-hour rhythm by the third day after the last injection. This rhythm was even more conspicuous if the next injection of depot tetracosactrin was delayed several more days. Moreover, a good response in the plasma corticosteroids was demonstrated in all four subjects following insulin hypoglycaemia, and in three out of four subjects given lysine vasopressin. In two subjects plasma immunoreactive A.C.T.H. levels were determined;[2] one showed a definite 24-hour rhythm while in the second both morning and evening levels were below the limits of