tion too early has long been recognised as undesirable. Dr St Leger is also clearly unaware that even those fortunate enough to be exempted from part I MFCM examinations have nevertheless to pay the fees for them, as otherwise he would recognise that the present policies of the Faculty of Community Medicine are founded on educational grounds rather than fiscal ones. After reading his letter it is hard to resist the temptation to generalise and conclude that perhaps after all the present policies are the right ones.

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¹ Beer, S, *Decision and Control*. New York, Wiley, 1966.
² Ackoff, R L, and Sasieni, M W, *Fundamentals of Operational Research*. New York, Wiley, 1968.

SIR,—As trainee community physicians and presumably therefore future “mediocre ‘Jacks-of-all-trades’” we take strong exception to Dr A S St Leger’s letter (20 March, p 709).

His sweeping dismissal of sociology and administrative theory suggests nothing if not an “uncritical assimilation of received opinion,” to use his own phrase, while his equating community medicine with administration reveals an ignorance of this field confirmed by the assertion that trainees uncritically accept the contents of their courses. As any teacher on the modular courses will confirm, we provide constant critical feedback which has helped to modify and improve our training.

From our “superficial” study of epidemiology we understand that it is based on the construction of logical hypotheses from carefully observed and quantified facts. We can therefore understand Dr St Leger’s apprehension at the prospect of being obliged to sit part I of the MFCM but do not feel that the correct remedy lies in altering the examination requirements.

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Constipation and soiling in childhood

SIR,—In my view Dr G S Clayden (28 February, p 515) overemphasises the importance of mechanical factors in the causation and treatment of this problem and fails to give sufficient weight to psychological environmental influences.

In this connection I would like to comment on the short-term outcome of 50 consecutive cases of severe soiling admitted to two hospital units for psychiatrically disturbed children situated near the city of Leeds because of failure of outpatient treatment, social factors, and severe associated problems. The mean age on admission was 8½ years. They were managed on a weekly basis and remained an average of 5 months. Faecal retention was present to some extent in the majority and was severe in one-third, in whom it responded to oral laxatives within a matter of weeks. Half the group had associated enuresis. Half were severely disturbed, mainly with conduct disorders. Half had very unsatisfactory home conditions. Two-thirds appeared to need the constant attention of a concerned adult to establish a normal bowel habit. All had stopped soiling for at least a month on discharge. Parents were involved in treatment as far as possible and had the children home every

weekend. We do not know the long-term outcome yet, although a follow-up study is currently being attempted. Whatever the original cause it seemed that the constipation and soiling had persisted in these children prior to admission because of the psychological environmental influences consequent on soiling, mainly the reaction of parents and other children. Once faecal retention was overcome because of the relaxed atmosphere and the use of oral laxatives it was still necessary to help the child develop a normal bowel habit. This aspect of the problem was hardly mentioned by Dr Claydon. Mechanical emptying procedures used from below were not necessary at all. In fact some children appeared to have developed psychiatric symptoms, such as phobias, in response to their previous use. Dr Claydon does not refer to the likelihood of this happening.

It can, of course, be argued reasonably that this was a very biased sample of soilers. However, similar findings were reported previously in the treatment of constipated soilers by oral laxatives and regular outpatient visits in a paediatric setting, with good results.¹ Also, in a group of 8-year-old children from the general population of Stockholm² it was considered that punitive reactions of mothers to the occurrence of soiling and embarrassment engendered by soiling at school were two factors encouraging faecal retention, and it was found that soiling children were somewhat reluctant to use the toilet.

Some doctors have managed to dispense with laxatives altogether and manage constipated soilers entirely as a psychological problem.³ I still find that quite large doses of oral laxatives may be necessary to reduce faecal retention while the child remains at home. It may be advisable in young children to keep them off school for a few weeks until a regular bowel habit is established. The most important aspect of management, however, is to support the mother so that she can stop reacting severely to the soiling and give the child plenty of encouragement when he or she starts to use the toilet regularly in the, hopefully, more relaxed atmosphere at home.

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¹ Berg, I, and Jones, K V, *Archives of Disease in Childhood*, 1964, **39**, 465.
² Bellman, M, *Acta Paediatrica Scandinavica*, 1966, **170**, suppl, p 1.
³ Jolly, H, *Proceedings of the Royal Society of Medicine*, 1976, **69**, 21.

Herpesvirus and cervical cancer

SIR,—I read with interest the latest (20 March, p 671) of the excellent series of leading articles you have produced on the relationship of carcinoma of the cervix to infections with herpes simplex virus type 2 (HSV 2).

As a venereologist I have been increasingly concerned about many aspects of genital herpetic infections, which are occurring nowadays with increasing frequency. This illness can be an extremely severe one for women, primary infections causing great pain, agonising dysuria, difficulty with micturition, and even retention of urine. Systemic reaction with high fever is common and meningeal involvement may develop. Herpetic cervicitis may be clinically obvious and severe, though the virus can frequently be recovered from a slightly inflamed or indeed apparently normal cervix in patients suffering from herpetic vulvitis.

Although most of the published work associates the genital strain of HSV with carcinoma of the cervix, many, if not the majority, of the cases of genital herpes seen, in my experience, follow orogenital intercourse and are therefore presumably due to type 1 or oral strains. We do not know if this strain shares the putative oncogenic potential of HSV 2, but if it does, judging by the number of cases currently being seen, a veritable epidemic of cervical dysplasia, carcinoma-in-situ, and carcinoma of the cervix should be observed in the next 10–20 years.

Many cases of genital herpes are not diagnosed as they present to the doctor as “cystitis” or “dysuria” and I would stress that every woman complaining of extreme dysuria should have her vulva carefully inspected as such a symptom nearly always means that genital herpes is present. I would strongly support the suggestion made in your article that an accurate diagnosis, preferably by culture of the virus, should be made whenever possible and I think that cytological review should be carried out (regardless of age) at least yearly intervals in all women who have sustained an attack of herpetic cervicitis until the role the virus plays (if any) in the development of carcinoma of the cervix is more precisely defined.

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Metabolic effects of bran

SIR,—In the studies of Mr A J M Brodribb and Dr Daphne M Humphreys (21 February, p 428) glucose tolerance curves were flatter in 37 patients tested with 50 g oral glucose after eating 24 g wheat bran daily for more than six months. This is of particular interest in view of the evidence that dietary fibre and other unabsorbable carbohydrates modify carbohydrate tolerance. Jeffreys¹ reported that bran decreased blood glucose levels when taken with glucose syrup and we have found that unabsorbable polysaccharides decreased postprandial glycaemia following a liquid meal containing glucose.² The latter observation has been repeated after solid “breakfast” meals in which guar gum (a storage polysaccharide from the cluster bean) and pectin (a polymer of galactouronic acid obtained from apples) were added to the bread and marmalade respectively. After an overnight fast each of five healthy volunteers ate a test and control meal in randomised order on two mornings 48 hours apart. The carbohydrate load (105 g) was the same in each meal. The mean maximum rise of blood sugar after the guar/pectin meal was only 40% of the control value ($P < 0.002$). Mean insulin levels were significantly lower after the guar/pectin meal, being only 35–54% of the corresponding control levels. Mean differences between test and control insulin levels ranged from 26 ± 5 to 37 ± 5 mU/l.

Van der Westhuizen *et al*³ have suggested that the flatter glucose tolerance curves seen in groups eating large quantities of maize meal⁴ may be due to an adaptation of the more distal part of the small intestine for glucose absorption. An alternative idea is that when natural unprocessed foods are eaten glucose absorption occurs equally well in any part of the jejunum, but that the consumption of refined carbohydrate by “Western” societies has resulted in an improved ability of the