Yakovlev describes the prevalence of degenerative lesions in the anterior convolutions of the frontal lobes and in the outer segments of the globus pallidus as the anatomico-pathological cause of this state. He is careful to add, however, that more than anatomical changes must be considered. The importance of the ends served by anatomico-physiological functions cannot be forgotten. As long as the ends remain valid, so may the physiological integrity of the organism remain.

This, I suggest, is the state of affairs in senile incontinence. Although her bladder is maimed and inefficient (from predominantly neurological causes) the old lady maintains control of it as long as the end it serves remains valid. When this end is assailed—as the result of pneumonia or other illness, or by an enforced bedfast state in which requests for bed-pans are ignored and she is pushed back into bed if she tries to get up to the toilet in the night—so the physiological efficiency which she may have clung on to at some considerable effort breaks down and she becomes incontinent.

The aim of our rehabilitation is to restore independence, and thus the relevance of bladder control.

Bladder stretching, under cystometrographic control, was described by Wilson[5] and not by me. The two most helpful measures I know of in treating incontinence at this stage are (*a*) two-hourly "potting" with a note made on each occasion by the nurse on a chart at the bedside as to whether the patient was wet or dry, and (*b*) atropine in water, by mouth. The former was introduced as an investigational procedure and found to have a striking therapeutic effect (for obvious reasons). The latter increases bladder capacity by diminishing tension and the incidence of uninhibited contractions.

No treatment of incontinence can have any success unless backed by the full understanding and co-operation of ward nurses. For this reason it is important that they should appreciate the physical changes present in the incontinent bladder as well as the psychological implications of hospital admission which Dr. Newman has so vividly described.—I am, etc.,

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Return of the Venereal Diseases

SIR,—I have read the article by Dr. F. J. G. Jefferiss (June 23, p. 1751) with considerable interest and would like to add a brief note of my own experience.

At the new Esso Refinery at Milford Haven I have been providing a medical service to seamen on the tankers calling here. In the last 18 months—from January 1, 1961, to June 30, 1962—I have seen 949 new cases of illness and injury including 35 cases of gonorrhoea (3.6%). The ages and nationalities of the cases are as follows:

Age	16–20	21–25	26–30	31 and Over	Total
British ..	3	6	4	1	14
Scandinavian	9	3	3	2	17
Other ..	—	—	—	4	4
Totals ..	12	9	7	7	35

These figures represent an alarming picture, especially when it is realized that the vast majority of these seamen were working coastwise in the United Kingdom, being infected in our own ports.

Dr. Jefferiss suggests four methods of improving control of venereal disease: (1) Limitation of immigration. (2) Education of the public. (3) Specialist treatment. (4) Education of medical students.

While agreeing in principle with his suggestions I should point out that in this area only three out-patient sessions are held each week, and these are at Swansea—a distance of 65 miles. To all practical purposes no out-patient specialist advice is available for seamen. Admittedly Milford Haven is an isolated port, but one wonders if specialist advice is as easily available outside London as Dr. Jefferiss imagines.

My experience also suggests that with penicillin available on board ship many cases of gonorrhoea are treated at sea without the benefit of any medical advice.

In my opinion a system of notification of these infectious diseases would be of value in control (the fee for notification would, however, have to be more realistic than the present fees if any success were to be achieved). The doctor notifying the case should be asked to identify contacts where possible. The names of contacts would then be sent to the appropriate V.D. clinic.

No doubt this suggestion will meet with criticism, but in view of the increase in the incidence of the venereal diseases, so clearly shown by Dr. Jefferiss, it would seem to me that it is time that the pros and cons of notification were re-examined.—I am, etc.,

Milford Haven, Pembs. W. M. DIXON.

Rest and Blood Flow

SIR,—Mr. N. L. Browse's papers (June 23, pp. 1714 and 1721) demonstrate that calf blood flow reaches its resting level before an hour of rest has elapsed. He states that this explains why early ambulation after surgery has no effect on the incidence of deep-vein thrombosis. In addition he has shown that a fall in blood flow occurred post-operatively in 75% of his patients for reasons possibly related to length of operation and type of anaesthetic. His recommendation is to keep operations as short as possible.

McLachlin *et al.*[1] have shown by cineradiography that dye injected into the dorsal vein of the foot and directed into the deep veins by tourniquet at the ankle was retained in the thigh channels for about nine minutes and in the valve pockets for 27 minutes in patients remaining supine and quiet. The stasis time was about one-third when voluntary contraction of muscles was performed and less when the foot of the operating-table was raised 15° above the horizontal.

Early ambulation may be ineffective in preventing thrombosis because stasis has already been prolonged. It would be interesting to study calf blood in subjects where the lower limbs have been raised at operation and subsequently, and to know if the type I and type III responses described by Mr. Browse are the same. May one hope that he will be able to fill yet another gap?—I am, etc.,

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