enuresis is essential if community paediatrics is to develop into a worth-while scientific discipline.—I am, etc.,

City of Nottingham
Education Committee,
Nottingham.

F. E. JAMES.

REFERENCE

- ¹ Mac Keith, R., *Developmental Medicine and Child Neurology*, 1968, 10, 465.

SIR,—I would agree (12 April, p. 63) with the basic concept of maturation of the nervous system as being an essential prerequisite for the establishment of bladder control. However, there are developmental periods when it is easier for the child to learn this faculty. Most parents make use of the optional times, acting on knowledge of the mental age or developmental age rather than by rote or according to the chronological age. The idea that maturation will inevitably occur ("he will grow out of it") must sound rather wry to those otherwise well-adjusted adults who have been or who still are afflicted with this problem.

It does not seem to me at all certain that it "is not due to unduly deep sleep." Nocturnal enuresis can be regarded as a sleep disorder. Many children, even including infants, are overstimulated by the current phrenetic "pop" subculture and become overexcited during the day and sleep the sleep of exhaustion for the few hours allowed for this purpose at night. Disc-jockey hypomania has invaded the nursery over the last few years. This seems to have become a real aetiological factor. Many of the several hundred cases for whom I have undertaken training with enuresis alarms have had to alter their sleep patterns in order to avoid sleeping through the alarm. Few parents do this (except of course deaf parents) and it is not an uncommon family comment "that the alarm awakes everyone in the house but him."

Most agree that secondary enuresis has a stressful precipitating cause. You mention "psychosocial factors." I have noticed the operation of circumcision to be of occasional significance, although admittedly a recent case was cured by this operation. Perhaps we might now call this procedure a psychosocial one.

After a relapse has occurred it becomes increasingly difficult to separate social and psychological causes from social and psychological effects. The taboo associated with enuresis is not as culturally significant as that associated with encopresis, but in some families of lower social class no great distinction is made between the two. However, it is the moral disapproval common in middle-class families which is apt to lead to later deviant behaviour and delinquency unless handled carefully. This is quite different from the initial training, where parents ought to be encouraged, not dissuaded, from showing firmness from time to time. If the child is not under the benevolent control of his parents he is unlikely to feel the security necessary to be able to control his own autonomic nervous functions. To suggest parents are wrong if they take a lead or show anxiety to toilet-train is not really fair and could lead to missed opportunities.

Fortunately most children pass from automatic potting to voluntary potting without a hitch and there is nothing punitive about it. One last point which you do not answer—why are boys more affected than girls?

Possibly because they are more prone to neurotic and behavioural disorders of all kinds. Why is this so? Perhaps because they are allowed noise, aggression, and violence as play and passive "entertainment." One thing is certain, the *laissez-faire* adage "Boys will be boys" gets us nowhere.—I am, etc.,

B. H. BURNE.

Amersham, Bucks.

SIR,—I would like to support the criticism of Dr. J. V. C. Braithwaite and Mr. A. R. C. Higham (26 April, p. 248) of the statement in your leading article on the causes of enuresis (12 April, p. 63) that "we" know that the condition is not caused by excessively deep sleep. How otherwise can one explain the examples quoted by Dr. Braithwaite of enuretic patients who take a dose of amphetamine on going to bed at night which would keep any normal individual awake all night, and yet sleep soundly. How can one explain the fact that an adult enuretic patient of mine is not only not awakened by a loud enuresis alarm bell but has to be shaken by other members of the family who are awakened from their sleep in other parts of the house?

The mere fact that the enuretic remains asleep until the next morning despite the fact that he or she has spent many hours lying in a bed which is soaked with urine must also indicate a failure to be aroused not only by the stimuli arising from a full bladder but also by other sensory stimuli which would awaken a normal individual. It is not suggested, of course, that all cases of enuresis are due to pathologically deep sleep, but this is certainly so in some cases.—I am, etc.,

Marple, Cheshire.

W. J. STANLEY.

SIR,—Like Dr. J. V. C. Braithwaite (26 April, p. 248), I used to believe that hypersomnia was an important contributory factor in enuresis.

When, however, researching into the aetiology of enuresis¹ one of us (M. M. B.) arranged for a control group of children in the hospital to be deliberately woken. To our surprise there was practically no difference in the incidence of hypersomnia among the enuretics compared to the other children. We concluded that few parents, except in wartime, make a deliberate effort to arouse their sleeping "normal" children, and so underestimate the prevalence of this sleep pattern.—I am, etc.,

R. F. BARBOUR.

Bristol 8.

REFERENCE

- ¹ Barbour, R. F., Borland, E. M., Boyd, M. M., Miller, Ashton, and Oppé, T. E., *British Medical Journal*, 1963, 2, 787.

Treating Glandular Fever

SIR,—In the *Drug and Therapeutics Bulletin*¹ there is an account of the treatment of glandular fever by corticosteroid therapy. The conclusions are that such therapy seems to shorten the duration of fever and the symptoms that accompany it. 40 mg. or

more a day of prednisolone is advocated in severe cases.

With a drug of such wide potentialities for good and evil, it might seem better to try a non-steroidal anti-inflammatory agent. For this reason Dr. P. L. Boardman and I suggested the use of indomethacin in glandular fever.² I have now treated six patients with glandular fever with indomethacin 25 mg. two tablets three or four times a day after food. In four of the six cases fever and pains were reduced and the patient felt much better. On discontinuing the drug in three patients symptoms rapidly returned.

General physicians in the days before antibiotics treated many febrile illnesses with antipyretic, analgesic agents purely for their therapeutic rather than curative effect. In a disease like glandular fever, if simple salicylates do not make the patient's lot easier, I consider there is a good case for using indomethacin, provided it is well tolerated, as it was in four of these six cases. In one headache due to the drug occurred, and in the other the patient did not show adequate response. In those rare cases of glandular fever associated with arthralgia and arthritis such treatment seems doubly indicated.—I am, etc.,

F. DUDLEY HART.

Westminster Hospital,
London S.W.1.

REFERENCES

- ¹ *Drug and Therapeutics Bulletin*, 1969, 7, 31.
² Hart, F. D., and Boardman, P. L., *Practitioner*, 1964, 192, 828.

Treatment of Angina Pectoris

SIR,—Your leading article on the treatment of angina pectoris (19 April, p. 134) overstates the case. It may be true that nitroglycerin does not increase the flow of myocardial blood in patients with myocardial disease. The authors quoted for this statement make no such claim. Aware of the limitations of their techniques for measuring coronary flow, they prefer to state that they cannot demonstrate an increase. A beneficial increase in flow sufficient to relieve angina is likely to be small, and may well depend upon a redistribution of flow in the coronary tree which could not be measured by current techniques.

The leading article appears to pose a paradox when in one paragraph it is said that the blood vessels in hypoxic muscle are maximally dilated and nitroglycerin does not increase myocardial blood flow, while in another paragraph that nitroglycerin is the cornerstone in treating angina. Coronary arteriography in patients with angina pectoris shows that angina is not uncommon in subjects with atheroma of the arteries in whom long collateral vessels have developed. These vessels themselves are not ischaemic or running through ischaemic areas. It is therefore misleading to suggest that they must be maximally dilated.

More evidence is needed before it can be accepted that coronary dilators such as trinitrin and prenylamine lactate do not act by dilating coronary arteries.—I am, etc.,

D. VEREL.

Northern General Hospital,
Sheffield, Yorks.