sent in a particularly acute form at Hull recently." This statement requires clarification.

You first deal with the problems of what treatment to institute with the newborn child with spina bifida and meningocele as highlighted by Dr. John Lorber.¹ However, you then quote the case from Hull as an example of what treatment should be offered. Here you are muddling two different concepts.

The child in question was born with a lumbosacral meningocele and did not fall within the groups with an obviously bad prognosis to which you refer. He was treated by early closure of his back and later a Spitz-Holter valve to control the developing hydrocephalus. When 3 months old he was placed in a foster home. Here he did very well until the age of 13 months, when the distal end of his shunt assembly blocked. His parents, although now having delegated his day-to-day care, refused operation. After protracted negotiation, the court was asked to intervene and decided in favour of operation.

In your article initial treatment is discussed and then the Hull case is quoted. Even in the earlier article, "Tragic Dilemma" (9 December 1972, p. 567), it is not made clear that this was not a primary operation and that we were concerned with the continuing care of a child who had already been treated. This is a very different case from non-intervention on adverse prognostic grounds as argued last week.—I am, etc.,

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¹ Lorber, J., *Archives of Disease in Childhood*, 1972, 47, 854.

SIR,—Your leading article (10 March, p. 565) is most valuable, but when you say that "the quality of survival was less satisfactory than had been hoped, and many children spent a life of repeated hospital admissions or of semipermanent care in residential homes" I think more is involved than the criteria for selection of cases at birth. Every district hospital that has a maternity department concerned with the delivery of more than 2,000 babies a year, particularly those in the high-risk areas, will soon find that there are a large number of these children needing prolonged treatment and education. At the present time at this hospital we have nearly 30 such children, the oldest 16 and the majority much younger. The problem of their education and general management is greatly simplified if they have management alongside children with other chronic handicaps, such as cerebral palsy; we care for about the same number of these. If this is done the numbers that each hospital must deal with make a large and comprehensive unit justifiable.

It has been said that it is not satisfactory to deal with these two categories of children side by side. This has not been our experience, but we are arranging for an independent assessment of the quality of education and management that we give to this combined group. The problem of their management through the emotional problems of puberty and their placement in satisfactory work in adult life is again a

strong argument for local provision and close contact with the home.

The problem demands a multidisciplinary approach; if the district general hospital is in close proximity to the day school, many departments of the hospital will be found to play an important role, not least that of child psychiatry. The regional paediatric surgeons and paediatric neurologists, through the mechanism of combined clinics and occasional admission to their special units, play a vital part. The nursing staff and junior medical staff of the district hospital learn much by direct experience and the family doctor can retain a meaningful place in the lives of these children. Co-operation with the local authority, medical, educational, and social service departments proves to be most fruitful.

The time has come for the voluntary bodies involved with these handicapped children to combine their efforts in pressing for such day facilities to be linked with each district general hospital and for the provision of local hostels, often for care in the short-term crisis, but occasionally for longer-term accommodation.—I am, etc.,

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Metoclopramide and Prochlorperazine in Radiation Sickness

SIR,—Prochlorperazine is a standard treatment for radiation sickness.^{1,2} Metoclopramide differs in that it acts locally by decreasing the sensitivity of the visceral nerves from the gastrointestinal tract as well as decreasing the sensitivity of the vomiting centre. It also restores normal gastric motility.³ Hence I felt it would be useful to compare the effect of these two drugs in radiation sickness.

Prochlorperazine 10 mg and metoclopramide 10 mg were put in white capsules of identical appearance. The drugs were randomly allocated to a series of numbered tins each containing a supply of capsules for one week and labelled week 1. A second series of tins labelled week 2 was prepared so that the alternative drug was given during the second week. The patients were instructed to take one capsule three times daily. A key to the contents of the tins was kept by the chief pharmacist, but the radiotherapist did not know the contents of the tins and the patients were unaware of any change in treatment during the second week. The patients were undergoing a wide variety of radiation treatment. They were not entered into the trial unless nausea or vomiting had already started. If vomiting or nausea ceased within a day or two of starting drug treatment the drug was recorded as effective. If symptoms were not controlled or returned when the change to the second drug was made it was counted as ineffective.

The results were as follows. Prochlorperazine given in the first week was effective in 11 cases and ineffective in 10; in the second week it was effective in 12 cases and ineffective in five. Thus the drug was effective in 23 out of 38 treatment courses (61%). Metoclopramide given in the first week was effective in 10 cases and ineffective in 12; in the second week it was effective in 10

cases and ineffective in six. Thus this drug was effective in 20 out of 38 treatment courses (53%).

It can be seen that there was no important difference in effectiveness between prochlorperazine and metoclopramide, regardless of which drug was used first.

I am indebted to the Beecham Group Ltd. for supplying the drugs used in this trial.

—I am, etc.,

H. W. C. WARD

Queen Elizabeth Hospital,
Birmingham

- Berry, G. H., Duncan, W., and Bowman, C. M., *Clinical Radiology*, 1971, 22, 534.
- James, W. B., and Melrose, A. G., *Clinical Radiology*, 1969, 20, 57.
- Solan, M. J., *British Medical Journal*, 1959, 2, 1068.

Not So Popular Psychiatry

SIR,—In your leading article (24 February, p. 435) you refer to a survey¹ which indicates that of 146 Sheffield and Manchester graduates in 1971 who held preregistration posts in those two regions, only two (1.4%) were to make psychiatry their first choice. The use of statistical data where the numerator is a very small number requires thoughtful handling. Without that survey being wrong, I can also report that of the 91 who graduated from Manchester in the summer of 1971 three, to my knowledge, came into psychiatry straight from their preregistration jobs. This represents 3.3% of the Manchester graduating class of 1971 opting for psychiatry as soon as they were able to, a very different state of affairs. This is about the right proportion of doctors who should be going into the specialty.

It is not true that at this medical school psychiatry is less attractive to medical students as a career now than it was in 1956. Three entrants to the specialty from each graduating year has been usual now for some years.—I am, etc.,

NEIL KESSEL

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¹ McLaughlin, C., and Parkhouse, J., *Lancet*, 1972, 2, 1018.

SIR,—I hope those of us who try to help medical students to understand the principles of psychiatry will gratefully heed the perceptive feed-back offered by Mr. R. F. Bury (10 March, p. 609). But I also hope he will not be diverted from his original intention to take up psychiatry as a career, because only those who recognize problems are likely to solve them.

Mr. Bury is right in observing that psychiatry is not "a medical specialty like any other"—if only because its patients are far too numerous for most of them to be treated by specialists. But it is still part of medicine, and while it may be quite appropriate to delegate a considerable amount of psychotherapeutic casework to others (after suitable training), doctors themselves (especially general practitioners) cannot evade the need for therapeutic competence. Any consultation with an emotionally disturbed patient will be either therapeutic or the opposite; and who but the family doctor can initiate help for those inner conflicts that first appear as somatic dysfunction or allay the fears that will otherwise prevent a patient from agreeing to a life-saving surgical operation?