

however, he seemed to completely change in personality from being a sleepy, placid baby to being a restless, demanding horror. He demanded feeds as often as hourly or two hourly—even through the night—and was very difficult to settle after feeds. Of course, I got the usual advice from my mother-in-law—“It’s your milk, dear, you haven’t got enough, or it’s too thin.” But I knew my physiology—all I had to do was let him suck, and Nature would do the rest. Nature did not.

With increasingly sore nipples and a baby continually screaming for something—apparently hungry, although he was rapidly gaining weight—I began to yearn for the simplicity of a bottle. At least I could then see what he had taken, and would know whether he was hungry or just bad tempered. The deciding point came after eight weeks of what can only be described as a nightmare, when my husband had to go to Malta on business, and I could accompany him. The decision was either to stay at home and battle on with the breast-feeding or to wean him on to a bottle, leave him with my mother, and go to sunny Malta for four days. Needless to say, the latter won and I have never regretted it.

I returned to my difficult baby with renewed energy, and I needed it. The change to bottle feeding had not altered my infant’s behaviour in the slightest—but it had altered mine. He still screamed all day long, but I no longer bared a breast at each scream but rather took him out for a walk, or carried him around strapped to me in a sling, as I knew from his milk consumption that he was unlikely to be hungry. I also discovered a new sense of freedom—I could go out shopping and leave my husband to feed him, and I could plan my return to part-time general practice. Night feeds also could be shared out, and my husband rapidly started to develop a relationship with his son which before had been totally absent.

It was five-and-a-half months before my child’s behaviour improved, and now, at almost a year, he is a delight. I have learnt many lessons from this experience—I still believe that “breast is best,” but I realise that in some situations bottle is more suitable. I feel that in our enthusiasm to promote breast-feeding it is important not to invoke a feeling of guilt in our patients who, like me, fail to breast-feed.

JANET GRAY

Knebworth, Herts SG3 6TA

### Enuresis

SIR,—With reference to your leading article (17 March, p 705) and the article by Dr A J Cronin and others (p 722), if enuresis is treated as casually as you suggest, it shows little understanding of its main cause. If the child is otherwise normal the cause of wet beds is a small bladder capacity. If you take the trouble to ask the mother to measure the amount of urine the child can produce after holding on as long as possible you will find that there is a very small capacity. The treatment of enuresis is to increase that capacity. If this is done the condition cures itself. My normal policy is to get the child over the next school holiday to have a drink every time he passes a tap and to hold on five minutes after it starts to hurt. Within two weeks or so the problem has normally solved itself. The condition is caused by mothers and grandmothers who, on seeing the child naturally squirming at play,

say, “Go and wee before you wet yourself.” This results in a small bladder and a wet bed. Bells, buzzers, and drugs are very rarely required.

Moonah, Tasmania

### Respiratory obstruction by epiglottitis

SIR,—I read with interest the report by Mr M Hardingham and Dr P N Young (4 August, p 309) of respiratory obstruction by the flaccid epiglottitis, and their comments on the phenomenon. A similar case illustrated my report<sup>1</sup> on the fiberoptic laryngoscope as a “steerable guide-wire,” rather than as an optical instrument, for difficult or trauma cases.

This patient had attempted suicide by cutting his throat with a pair of scissors, resulting in a narrow wound penetrating the thyrohyoid membrane and amputating the epiglottis. The epiglottis, held only by mucosal strips, had impacted over the laryngeal inlet, while the patient breathed through the neck wound. Conventional oral intubation with topical anaesthesia was possible only by means of the extreme manoeuvrability of the fiberoptic laryngoscope, while the patient breathed via an endotracheal tube through the neck wound.

There was structural rather than functional damage to the epiglottis in this patient, so that patients with both respiratory obstruction and neck wounds may be doubly at risk—which emphasises the dangers of inexpert anaesthesia mentioned in the report.

J R DAVIES

Surgical Clinic,  
Serafimerlasarettet,  
11283 Stockholm, Sweden

<sup>1</sup> Davies, J R, *British Journal of Anaesthesia*, 1978, 50, 511.

### Travel and health risks

SIR,—Professor Brian Macgrath’s suggestion (18 August, p 443) that the DHSS printed warnings against malaria be enclosed within travellers’ cheque folders is admirable enough, but surely as a week’s prophylaxis against malaria costs less than half a penny (pyrimethamine 25 mg) might it not be more effective for airline stewardesses to hand them out before flights through endemic areas instead of the customary glucose sweets?

ERIC J TRIMMER

Loudwater, Herts WD5 4JE

### Measles and vaccine protection

SIR,—Dr G A Jackson’s survey (4 August, p 332) of measles in children who had been vaccinated against the condition failed to take into account the population at risk: the number of children susceptible to measles (having no history of measles and being exposed to the possibility of infection) who were in the specified area during 1978. If that number were 1470 and they were vaccinated and then exposed to infection with measles the fact that 147 developed the illness would indicate a protection rate by the vaccine of 90%.

Without the number of susceptibles, the conclusion that the vaccine had lost potency is more than these data will support—a point

that is well illustrated by Canadian workers in WHO’s *Weekly Epidemiological Record* (1979, 54, 210).

L J FISH

Duncan, Flockhart, and Co Ltd,  
London E2 6LA

P B STONES

Biological Division,  
Glaxo Operations UK Ltd,  
Speke, Liverpool L24 9JD

### Unusual manifestation of hypocalcaemia

SIR,—As Dr K Graham and others have recently pointed out (2 June, p 1460), the clinical manifestations of hypoparathyroidism in the elderly can be atypical. I would like to draw attention to an unusual physical sign of hypocalcaemia in an elderly person.

The patient, an 81-year-old man, had been confused and restless during the three weeks before he was brought into hospital. On admission, he was disorientated and uncooperative. He had a marked dorsal kyphosis and the head was stretched forward. The trunk was so rigid that his head and neck did not touch the pillow when he lay on his back. Ankylosing spondylitis was suspected but there was no x-ray evidence for this. Laboratory investigations showed: serum calcium 1.25 mmol/l (5.0 mg/100 ml); phosphorus 2.8 mmol/l (8.5 mg/100 ml); alkaline phosphatase 3.7 Bodansky units; urea 3.9 mmol/l (20 mg/100 ml); albumin 36 g/l; globulin 28 g/l. After treatment, the calcium rose to 2.2 mmol/l (8.8 mg/100 ml), while the patient became fully conscious; his back and head assumed a normal posture and the spasticity disappeared. Idiopathic hypoparathyroidism was diagnosed.

There have been several reported cases of idiopathic hypoparathyroidism presenting with a clinical picture reminiscent of ankylosing spondylitis.<sup>1,2</sup> In these cases, however, there were paraspinal calcifications on the radiograph and the condition was not reversible when the serum calcium returned to normal.

RAFAEL J SCHEN

Geriatric Department,  
Ichilov Hospital,  
Tel-Aviv, Israel

<sup>1</sup> Adams, J E, and Davies, M, *Postgraduate Medical Journal*, 1977, 53, 167.

<sup>2</sup> Chaykin, L B, Frame, B, and Sigler, J W, *Annals of Internal Medicine*, 1969, 70, 995.

### Chronic ambulatory peritoneal dialysis

SIR,—I read with interest your leading article (28 July, p 229) on chronic ambulatory peritoneal dialysis. May I draw your attention to two points?

The correct name of the technique you described is continuous ambulatory peritoneal dialysis or CAPD. By describing it as chronic you miss one of the major points of this technique—that is, it is continuous, which is a unique characteristic of this treatment.

The continuous ambulatory peritoneal dialysis was first described by Popovitch and his colleagues in 1976, as you have mentioned, but these authors were using dialysate in glass containers, resulting in a high incidence of peritonitis. The technique that you describe in your editorial in which “while the dialysate is in the peritoneal cavity the plastic tubing set and the bag are folded into a small container which is held around the patient’s waist” is the Toronto Western Hospital technique for CAPD, which was first presented at the meeting of the American Society for Artificial Internal Organs in 1978.<sup>1</sup> Using this technique we have now trained 95 patients and our