with intravenous feeds for nutritional support while the remaining length of small bowel was taking over the function of the resected bowel. On this regimen he improved steadily and could tolerate a low-fat diet and oral antituberculosis treatment when he was discharged nine weeks after operation. Seven months later he was entirely well.

Discussion

Though uncommon in the indigenous population in Britain,¹ abdominal tuberculosis should not be forgotten in the differential diagnosis of abdominal symptoms, especially when patients are suspected of having Crohn's disease. The symptoms, signs, and results of investigation in the two conditions are so similar that no specific pattern helpful in the differential diagnosis is likely to emerge. Abdominal tuberculosis occurs most commonly in the ileocaecal region or peritoneum,² and diffuse disease of the small bowel alone as seen in our patient is unusual. It is important to make the correct diagnosis since steroid treatment of our patient probably precipitated the rapid progression of the disease and helped to determine the extent of the bowel resection.

It is difficult to see how the diagnosis could have been made in this patient. Accurate diagnosis of abdominal tuberculosis is possible only with a high index of suspicion and adequate histological and bacteriological material. Laparotomy is un-

likely to be performed early in suspected Crohn's disease in view of the high morbidity associated with surgery in this condition.³ There are ways to obtain a tissue diagnosis without incurring the risks of open operation. Random peritoneal biopsy in the right iliac fossa under local anaesthetic⁴ has helped in the diagnosis, and endoscopic biopsy in patients in whom the colon and caecum are affected should be considered when there are atypical features or when response to treatment is poor.⁵ These procedures would probably not have helped our patient, and some of these patients are likely still to be misdiagnosed in any country where Crohn's disease is so common and abdominal tuberculosis is so rare.

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Today's Treatment

Use of anaesthesia

Anaesthetists in the obstetric department

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It is a characteristic of clinical practice within a hospital that the anaesthetist has the facility of being all things to all men, and that he (or almost as often, she) can restrict or extend his activities to suit the local demands and opportunities. The obstetric anaesthetist is no exception to this. In practical terms his role within a small obstetric unit will be very limited; in a larger unit his involvement will be deployed over a wider field, and its scope will become dependent on factors other than size, such as the quantitative and qualitative availability of anaesthetic and paediatric staff, and the degree of enthusiastic collaboration displayed by the obstetric and midwifery staff members.

There are five major areas of potential involvement: (a) the administration of anaesthesia for obstetric surgery; (b) consideration of systems for relieving pain in labour; (c) neonatal resuscitation; (d) intensive care of the seriously ill mother; and (e) intensive care of the seriously ill infant.

Anaesthesia for obstetric surgery

Initially, and for many decades, anaesthesia for obstetric surgery was almost the sole item of engagement by anaesthetists in obstetric units. With the exception of very few interested anaesthetists it was a tangential occupation, usually delegated to the on-call, under-trained junior anaesthetist (except for private patients), and accepted very much on sufferance by the anaesthetic establishment. Increasing appreciation of the challenges provided by obstetric patients and of the hazards to which anaesthesia exposes them, has helped to bring about a minor revolution.

The obstetric anaesthetist has now accepted the responsibility of not only providing anaesthesia (whether general or regional), but also of defining the prophylactic measures necessary to reduce the dangers associated with these activities and of rigorously supervising their sustained application. Such measures include the provision of appropriate diet, antacid prophylaxis, and advisable maternal posture during labour and delivery; the provision of anaesthetic assistance and advised apparatus at critical times such as induction of general anaesthesia; attention to fluid replacement and the anticipation of blood loss; and the provision of an appropriately equipped and staffed postoperative recovery room.

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Relief from pain in labour

Collaboration in the application and supervision of relief from pain and anxiety during labour has been an important part of obstetric anaesthetic practice. Although currently the provision of lumbar epidural analgesia has seized the public and professional imagination, the obstetric anaesthetist by no means confines his interest to that technique. He must have a mastery of all available means of providing relief from pain and anxiety—psychoprophylaxis and relaxation exercises, inhalational and systemically administered agents, and other techniques of local analgesia (including spinal and caudal block). In gaining this mastery he has to learn much that was not in his basic anaesthetic training. He learns that the pregnant woman differs considerably in many important respects from the “standard human subject.” In her physiological characteristics, her metabolic responses (including her capacity to redistribute, metabolise, and excrete drugs), as well as in her anatomical features, she is truly a member of the “third sex.”¹

Additionally, the obstetric anaesthetist appreciates that the fetus is exposed to the effects of almost any treatment that he is likely to give the mother, and he must consequently have knowledge of placental physiology and the likely range of fetal responses. Protection against pain and anxiety in labour starts long before the mother enters the delivery suite. The obstetric anaesthetist co-operates with midwives, obstetric physiotherapists, and obstetricians in raising the confidence and self-assurance of the mother by contributing lectures and demonstrations in classes for antenatal preparation for childbirth. He also teaches pupil midwives—by obligatory formal lectures and informal demonstration and discourse—the elements of his and their common trade.

Neonatal resuscitation

Rough though reliable estimates suggest that, because of the deplorable lack of neonatologists in Britain, anaesthetists conduct about half of neonatal resuscitations. The anaesthetist, given his professional understanding of cardiorespiratory physiology and pharmacology, and his facility to intubate, is well equipped to fulfil this role. It may lead, however, to the potential danger of his having to look after two “at risk” patients simultaneously, and anaesthetists will welcome a considerable increase in a cadre of suitably experienced neonatologists to take over this responsibility.

Demarcation disputes have disappeared from all but a few antiquated centres, and there is general agreement that the depressed neonate should be resuscitated by the most experienced of the immediately available attendants (anaesthetist, paediatrician, or midwife). The anaesthetist is likely to maintain a role in teaching midwives and junior residents the elements of neonatal resuscitation.

Intensive care of the seriously ill mother

Intensive care of the seriously ill mother is well within the province of the obstetric anaesthetist, by virtue of his experience in non-obstetric intensive therapy units wedded to his understanding of the attributes of the “third sex.” Most mothers in this category will be those with moderate or severe pre-eclampsia, but among the remainder will be those with a severe cardiac lesion, diabetes, renal disease, or disease of the central nervous system, as well as items of specific obstetric pathology. The greatest hazard to which such a mother can be exposed is that of consultation with a physician or surgeon who knows little about pregnancy.

In the absence of suitably experienced advice and help from non-obstetric colleagues, the obstetric anaesthetist should have the facility of adopting the role of general physician to the obstetric team. He will, in any event, collaborate with his

obstetric and midwifery colleagues in constructing protocols to be followed during the care of seriously ill mothers and in furnishing—and maintaining in a state of preparedness—the full range of equipment and drugs that might be required for this purpose.

Intensive care of the seriously ill infant

Somewhat similar remarks are applicable to the participation of the anaesthetist in the care of the critically ill infant, although here, historically, his interests have been limited mainly to the problems of ventilatory support. With the increasing and welcome tendency to regionalisation the anaesthetist's role here is diminishing, although he will doubtless continue to be a welcome adviser on matters of ventilator equipment and its application, and on the potential effects on the infant of drugs received and procedures undertaken before and during delivery.

Other responsibilities of the anaesthetist

It will be seen that the potential role of the anaesthetist in an obstetric unit is a widely ranging one—as practising clinician, supervisor, teacher, and, above all, co-ordinator. He has other responsibilities as an administrator, not the least of which is that of supervising the maintenance of informative clinical records, so that successes and failures, and lessons learnt, will not be overlooked or forgotten. His work is probably the most important and professionally rewarding in the whole of anaesthetic practice, because half of his patients have potentially the longest life-span in the community, and the other half have the responsibility of rearing those in the first category to the age of their own responsibility. The onus is on our administrators and medical colleagues to make good the woeful insufficiency of committed obstetric anaesthetists in Britain.

Reference

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Why does cold weather cause frequency of micturition in some elderly people?

There has been no unequivocal evidence on mechanism(s) causally linking cold weather to frequency of micturition, particularly in the elderly. The physiology of micturition is complex, and the nervous mechanisms responsible are not yet completely known. It is, however, accepted that the desire to micturate results from distension of the bladder, which depends on the rate of filling of the bladder and its ability to accommodate urine, the degree of excitability of nerve endings in the pelvis that constitute part of the reflex mechanisms of micturition, and, in addition, voluntary control subserved by higher centres.¹ The mechanisms responsible for changes in frequency of micturition in response to alterations in ambient temperature are not known. Possible links can be proposed from the available evidence that, firstly, diuresis occurs during exposure to cold; this diuresis is attributed, at least partly, to changes in the rate of liberation of the antidiuretic hormone.² Secondly, the desire to micturate could be associated with the reduced ability of the bladder to elongate its fibres as the contents increase and irritation of mucous membrane of the bladder wall; in the elderly these changes could result from incomplete emptying of the bladder and the presence of subclinical urinary infections.

¹ Kuru M. *Physiol Rev* 1965;45:425-94.

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