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Regional Hospital Staffing

SIR,—Four years ago the Department of Health and Social Security imposed an embargo on the creation of new appointments at registrar level. As a consequence some responsibilities of registrar level are now being covered by senior house officers and requests to appoint registrars in new or expanded units are refused.

During this period appointments at senior registrar level have increased by 25% but almost entirely outside the regional hospitals.¹ Over the same period there has been a 43% increase in senior house officer appointments, but in our view this does not provide adequate experience for the safe care of patients.

This action is jeopardizing the safe and efficient running of some departments in regional hospitals and of new or expanded units. Consultant cover for these units is obtained either by appointing new consultants or by increasing the work load of existing consultants. We feel it is dangerous and unrealistic not to appoint at the same time resident junior staff of sufficient experience, as they are likely to be the only ones immediately available when any emergency arises: the only suitable junior staff fulfilling these criteria must be of registrar status or above.

The 506 members of the Regional Hospitals' Consultants and Specialists Association who have signed this letter have personal experience of this problem and wish to point out strongly the dangers of trying to run a department or unit where emergencies are likely to arise without suit-

ably experienced junior staff. The distribution of the signatories among the specialties is as follows: general surgery, 144; anaesthetics, 76; general medicine, 76; psychiatry, 49; obstetrics and gynaecology, 87; orthopaedics, 23; paediatrics, 13; pathology, 11; E.N.T., 11; radiology, 10; plastic surgery, 1; venereology, 1; ophthalmology, 3; geriatrics, 1.—I am, etc.,

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¹ Department of Health and Social Security, *Digest of Health Statistics*. London, H.M.S.O., 1971.

*The names of the 506 consultants and specialists in England and Wales who signed this letter appear on advertisement page xviii.—Ed., B.M.J.

Renal Agenesis and Pulmonary Hypoplasia

SIR.—The association of bilateral renal agenesis in the newborn infant with a characteristic facial appearance is well known.¹ Pulmonary hypoplasia is almost always present in these infants,² and both this and the facial appearance are believed to result from the characteristic deficiency of amniotic fluid due to the renal abnormality. Severe renal malformations not amounting to agenesis may also be associated with pulmonary dysplasia, often complicated by pneumothorax and pneumomediastinum.³ The frequency of absence of kidneys and

related gross renal congenital anomalies is given as 0.3% of all still-births and deaths up to 6 weeks of age.⁴

Only half the cases of renal tract malformation are associated with the typical "Potter facies."³ A gross congenital renal anomaly may therefore not be readily identifiable by the facial appearance at birth but the baby may still suffer from pulmonary dysplasia.

While providing a neonatal resuscitation service for a maternity unit (4,500 deliveries yearly) we have seen in the past two years six babies, all later found to have a gross renal anomaly, who failed to establish respiration spontaneously and whose lungs did not expand adequately with the normal pressures used in neonatal resuscitation—that is, 40–50 cm water.⁵ At necropsy all these babies were found to have pronounced pulmonary hypoplasia in addition to their renal anomalies. Three had pneumothorax and pneumomediastinum. One of them was at first thought to have congenital heart disease, but this was disproved by cardiac catheter studies. Only two of the six babies had an abnormal facial appearance, and only one (see Fig.) could thus confidently be recognized as a case of Potter's syndrome.

The following points arise from our experience. Firstly, a diagnosis of severe congenital renal anomaly should be considered in babies who, despite the endotracheal tube being correctly placed, require excessive pressures to expand their lungs during resuscitation. Secondly, only a proportion of babies with congenital renal anomaly and pulmonary dysplasia show a characteristic facial appearance: its absence does not exclude the diagnosis. Thirdly, these cases

may closely simulate congenital heart disease, and the possibility of gross renal malformation with pulmonary hypoplasia should be

considered in the differential diagnosis of any atypical case of respiratory distress in the newborn period. Finally, we would like to emphasize the importance of routine necropsy in the newborn, particularly in the circumstances quoted above. Quite apart from the academic value of making a correct diagnosis, it may bring some comfort to parents to know that a renal malformation incompatible with long-term survival was present, particularly as it is most unusual for this abnormality to recur in a subsequent pregnancy.

We wish to thank Drs. B. R. Silk and C. J. E. Wynne-Williams, each of whom allowed us to report a case under their care and we are also grateful to Dr. R. A. Sladden for histological reports.—We are, etc.,

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¹ Potter, E. L., *American Journal of Obstetrics and Gynecology*, 1946, 51, 825.

² Bain, A. D., and Scott, J. S., *British Medical Journal*, 1960, 1, 841.

³ Liberman, M. M., Abraham, J. M., and France, N. E., *Archives of Disease of Childhood*, 1969, 44, 471.

⁴ Davidson, W. M., and Ross, G. I. M., *Journal of Pathology and Bacteriology*, 1954, 68, 459.

⁵ Miller, R. D., and Hamilton, W. K., *Journal of the American Medical Association*, 1969, 210, 1090.

Immunological Control of Schistosomiasis

SIR,—Your recent leading article (12 August, p. 366) outlined some of the interesting current research into immunological aspects of schistosomiasis. May I comment upon several points which I believe to be relevant?

Both epidemiological and experimental evidence indicate that some resistance to superinfection is developed, but as yet we have little information on how the immune responses in man are affected by the pattern of exposure to infection. Are the responses in localities where transmission is more or less perennial and at a relatively low level the same as in places where transmission is seasonal and often massive? Though heterologous immunity between different species of schistosomes has been demonstrated in experimental animals it is not a universal phenomenon. Double infections in man with *Schistosoma haematobium* and *S. mansoni* are common in many areas. In the Transvaal *S. haematobium* and the bovine *S. matthei* occur together in man with evidence of hybridization and often in company with *S. mansoni*.¹ In Cameroon *S. haematobium* and *S. intercalatum* occur together in at least two localities, again with possible evidence of hybridization.² In parts of West Africa, Morocco, and Iran *S. haematobium* and *S. bovis* are often transmitted by the same species of snail at the same sites, and though in these cases there is no evidence of cross-infection between the human and cattle parasites there is at the same time nothing to suggest that there is any cross-immunity either. The human parasites may be non-pathogenic in cattle but infections of *S. mansoni* in calves are capable of reaching maturity with the passage of viable eggs. Would it be an acceptable risk to introduce a pathogenic human parasite into an area where it might become established?

Schistosomiasis is a disease of rural areas, usually in countries with limited economic resources. The cost of schistosomiasis control based upon the use of expensive chemicals and drugs has already proved to be beyond the means of many of these countries, but rural improvement schemes involving the proper use of water resources are vital to their economy. The incorporation of environmental control measures into such development projects could lead to beneficial and lasting effects on the incidence of not only schistosomiasis but also other parasitic diseases. The eventual control of schistosomiasis will be in the hands of those who suffer from the disease. They will need guidance on how this can be achieved, but if the advice which is given is incompatible with local economic development it is likely to go unheeded.³ Already some pilot environmental control schemes are showing promising results.^{4,5} If, as you suggest, the people in endemic areas are becoming more sophisticated and are not prepared to tolerate parasitic infections this would seem to be an appropriate time to encourage the development of local environmental control schemes in association with the necessary elements of health education.

The construction of new irrigation schemes in endemic areas must include provision of adequate water facilities, both domestic and recreational, and proper consideration must be given to the siting of accommodation for the work force. The cost of attending to these details will normally be only a very

small fraction of the total investment in the whole scheme⁶ and the neglect of such installations must be condemned as highly irresponsible.—I am, etc.,

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¹ Pitchford, R. J., *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1959, 53, 285.

² Wright, C. A., Southgate, V. R., and Knowles, R. J., *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1972, 66, 28.

³ Wright, C. A., *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1969, 63, Suppl. 77.

⁴ Pitchford, R. J., *South African Medical Journal*, 1970, 44, 475.

⁵ Barbosa, F. S., Pinto, R., and Souza, O. A., *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1971, 65, 206.

⁶ Arfaa, F., *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1969, 63, Suppl. 93.

Ultrasound for Detecting Peristalsis

SIR,—Ultrasonics offers a means of detecting postoperative recovery of bowel activity, and the following study, using a standard obstetric type of ultrasound device such as is used to detect the fetal heart beat, was done to compare the diagnostic value of ultrasound with that of using a stethoscope.

Sixty-seven patients were observed daily with both stethoscope and ultrasound after they had had an operation. The period of observation in each case was five minutes, and the postoperative day on which peristalsis was detected by each method was noted. In all the patients bowel movements were detected ultrasonically before they were heard by stethoscope. Peristalsis was detected on average 24 hours before bowel sounds were heard, and peristalsis was followed in 64 cases by the passage of faeces within 48 hours (see Fig.).

The same technique was used to monitor a case of ileus treated with neostigmine by the method of Neely and Catchpole.¹ The neostigmine infusion was stopped when bowel movement was detected by ultrasound, and this was five minutes before sounds were heard by stethoscope. The outcome was successful with a lower dose of neostigmine than would have been given if only auscultatory monitoring had been used.

A number of methods have been used to assess bowel motility, including intraluminal balloon manometry,² pressure transducers,³ and radiotelemetry pills.⁴ An external method using microphones (phonoenterography⁵) produces results which can be difficult to