dialysis and non-dialysis group were comparable for age and sex and whether the apparent differences in small numbers of patients was statistically significant. We studied the immediate effect of dialysis and found no significant difference in the peak acid output measured in the same 14 patients before and after dialysis,² but on reviewing our data we find that the basal acid output was significantly reduced after dialysis ($P < 0.05$). The peak acid output measures the parietal cell mass and perhaps its sensitivity to pentagastrin, but the changes in basal acid output, though less reproducible, may reflect the changes in urea and electrolytes produced by dialysis.—I am, etc.,

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¹ Fillastre, M. P., Blaise, P., Ardaillou, R., and Richet, G., *Revue Française d'Études Cliniques et Biologiques*, 1965, 10, 180.
² Gordon, E. M., Johnson, A. G., and Williams, G., *Lancet*, 1972, 1, 226.

Late Onset Psychosis

SIR,—On reading Dr. I. Kolvin's article (30 September, p. 816) about emotional problems in childhood and adolescence I was puzzled by an apparent lack of logic in the fourth of his five points of difference between infantile psychosis and the psychosis of later childhood. Dr. Kolvin states that "the low rate of schizophrenia in the parents of infantile psychotics and the significantly high rate in the psychosis of later onset suggests a genetic connection between late onset psychosis and adult schizophrenia." This statement is misleadingly structured.

Presumably the first part of the statement means (though this is not entirely clear from the text) that the parents of infantile psychotics have been found to have a low rate of schizophrenia whereas the parents of children with psychosis of later onset have been found to have a high rate of schizophrenia, the difference between the two groups being large enough to be significant. The inference of a connexion between psychosis of later onset in the child and adult schizophrenia in the parent follows from the high rate observed in this group. On the evidence only of the different rates in the two groups there is, however, no logical sequence in the suggestion that the connexion is "genetic." It might equally be an "environmental" link (exposure to a common factor or the effect of the adult's disorder on the child).

The structure of the statement was probably produced in an attempt to summarize the findings of a number of studies in one sentence, but the result is both confusing and misleading.—I am, etc.,

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Fungal Contamination of Bacteriological Swabs

SIR,—Drs. A. D. Bremner and Milcent H. S. Bell (21 October, p. 175) draw attention to the presence of fungal mycelia in polyvinyl sponge employed in cervical smears. I draw attention to another potential source of confusion during microscopy. In my experience some batches of commercially

available bacteriological swabs contain yeasts without hyphal forms, despite their sterility. These yeasts may be overlooked during casual microscopic inspection of purulent material, but caused us confusion in eye and vaginal swabs.

If yeasts are seen in stained films but cannot be cultured the confusion is invariably resolved, in my experience, by examining stained films of a small quantity of saline in which an unused swab has been vigorously stirred.—I am, etc.,

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Urinary Incontinence in Women

SIR,—Your leading article on incontinence in women (23 September, p. 717) confirms that this is a difficult and confused subject. For those not actively engaged in its investigation we would like to offer further news.

Firstly, the good news. The fundamental abnormality underlying the symptom is surely the result of bladder neck incompetence. The normal bladder neck mechanism is securely stress competent. If it becomes incompetent stress continence depends on the efficiency of the distal mechanism, and, unlike that of the male, this cannot be relied on—partly, at least, because the bulk of the voluntary extrinsic sphincter, once known as the "compressor urethrae," is pathetically small in the female. The concept of the "posterior angle" has been escalated to mythology and must surely be laid to rest. Its goniometric absence may indicate that the bladder neck is unlikely to be competent but its presence, particularly when surgically reproduced, is by no means evidence that it is functionally occlusive, let alone stress competent. Fortunately there are better ways of assessing bladder neck function.

The bad news is that the problem of stress incontinence is often much more complex than we have been taught and perhaps thought. Incompetence of the bladder neck may result from its weakness, but an entirely normal mechanism may be rendered incompetent as a result of the "open sesame" detrusor contraction associated with detrusor instability and provoked by simple cough or posture change. The clinical potential of the specific instability is evident but its precise importance both in relation to diagnosis and to treatment remains to be defined and detailed prospective studies are under way.

Significant detrusor activity associated with the trigonal/bladder-neck opening mechanism in the female is not easily measured. Diagnostic detrusor pressure changes are often minimal and often completely masked on a total-bladder-pressure record. They currently necessitate measurement by electronic subtraction (total bladder pressure minus intra-abdominal pressure). Smooth muscle myography presents problems. The new electronic nappy for objective evaluation of the timing and extent of leakage, may prove important in assessment. It is to be hoped that it will be possible to simplify these relatively sophisticated investigations for wider clinical use as their importance becomes more clearly defined.

In the meantime we agree that the actual

symptoms of urgency and incontinence do not always correlate accurately with detrusor instability and, furthermore, that a clinical history and examination can no longer be regarded as sufficiently objective for the critical evaluation of various forms of treatment. The management of overt detrusor instability remains a major problem. We have not achieved the excellent results of drug treatment, reported by Moolgaoker and others,¹ in which 15 out of 17 patients seem to have been cured or improved with anti-spasmodics, sedatives, or ephedrine. The results of surgery may also be somewhat disappointing, for though some patients with detrusor instability may be helped by operations which improve urethral function the longer term results may not be so encouraging.—We are, etc.,

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¹ Moolgaoker, A. S., Ardran, G. M., Smith, J. C., and Stattworthy, J. A., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1972, 79, 481.

Future of Child Guidance Clinics

SIR,—Despite the fact that the reorganization of the National Health Service is imminent it seems that the future of the child guidance clinics is still uncertain. Though child guidance clinics have practised community and family therapy by casework long before its importance was recognized by other medical and social agencies, and child psychiatrists created well over 50 years ago the concept of team-work which is now the basis of the new social services, little attention to the future of this service and the status of its staff has been given in the Seebohm Committee's recommendations or in the Green Paper and Consultative Document.

It seems that health, education, and social services are competing for this valuable prize, but history clearly connects child guidance and psychiatric services for children with the health and education departments. It was my privilege as a representative at the Special Representative Meeting of the B.M.A. in Leicester 1971 to put an amendment on behalf of the Hendon Division which emphasized the essentially medical nature of child guidance, which was unanimously accepted.¹ It has also been suggested that diagnostic and therapeutic clinics should be separated and organized by the education and health services respectively, but this would, in my view, be a mistake, since diagnoses and treatment form integral parts of the same process of helping disturbed children. However, I am sure that despite their very close co-operation the separate areas of competence and organization of child guidance and school psychological services will have to be maintained.—I am, etc.,

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¹ *British Medical Journal Supplement*, 1971, 3, 105.