Causes of Enuresis

SIR,—In your excellent leading article of the causes of enuresis (12 April, p. 63) you include among the things we “know”that do not cause the condition excessively deep sleep.

How do we know this? It is a statement that I have often heard or read, but I have never come across any proof of this opinion. On the other hand, 13 years ago I asked the mothers of 273 enuretic children the simple question, “Is he difficult to wake?” and 68% replied, “Yes.” The same question was put to the mothers of 500 children attending outpatient clinics for other reasons, and only 23% replied in the affirmative.

Last year I saw 250 children at the Leicester School Clinic with congenital enuresis, and 179 (72%) were said to be deeply exceptionally heavily. Moreover, we have nine enuresis alarms in circulation, which cause a gratifying number of apparent cures in some very difficult cases. The failures are nearly all due to the patient not waking the patient, although it wakens the parents and all the other non-enuretic members of the family.

Lastly, I have this afternoon seen an enuretic girl of 10 who takes 15 mg. of dextroamphetamine a night—and still sleeps soundly—I am, etc.,

Leicester.

J. VERNON BRAITHWAITE.

Severe Self-poisoning

SIR,—I was interested to read Dr. G. R. Burston’s account of the management of severe self-poisoning in Sunderland (15 March, p. 679). It is stated that 44% of the sample were discharged directly home to the care of their general practitioners. Does this imply that they did not receive psychiatric screening?

Self-poisoning carries not only an increased risk of further self-poisoning (as the paper shows), but further fatal episodes, regardless of the apparent seriousness of the initial attempt. For this reason the Hill report recommends that all cases of self-poisoning should receive psychiatric attention. In the Bolton group of hospitals, with a case load last year of 260 attempted suicides, 92% of cases were screened. Certainly all cases of

the severity described in the paper were dealt with by either inpatient or outpatient psychiatric services. It has thus been possible to achieve a virtually complete psychiatric service. This may be an advantage of having a psychiatric unit in a general hospital—I am, etc.,

J. H. BROOKS.

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Granules of Electrolytes for Infants

SIR,—Prompt oral treatment of infants who are vomiting or have diarrhoea can prevent or lessen the degree of dehydration and make emergency intravenous therapy unnecessary. In these conditions oral dextrose solution is contraindicated, as its use does not replace lost ions; an electrolyte solution is required. In reminding readers of this, you suggested in a leading article (13 January, 1968, p. 70) that it would be helpful to have a solution tablet containing the required electrolytes, which could be used to make into feeds.

This idea was investigated here, but in the end proved more practicable to prepare granules designed to be dissolved in sterilized distilled or boiled tap-water to produce a solution suitable for use as a “feed.” The formula is based on one given by Talbot and his colleagues, with the addition of dextrose and the minor modifications found necessary for the preparation of granules.
Caesarean section
Assisted delivery which
Age <25
Over IV.-Variations of all puerperium is others...
Phosphate ... 2:0"
Glucanote ... 2:0" in 5% dextrose solution.

Suppression of Lactation

Stir,-The reports by Daniel and his colleagues1 and Professor T. N. A. Jeffcoate and others (5 October, p. 19), both suggesting that the suppression of lactation in the puerperium is associated with a higher incidence of thrombosis, prompted us to examine the evidence in this region. The case records of all women delivered in hospital in Aberdeen over a period of four years, from 1958 to 1961 inclusive, were examined.

Twin deliveries and stillbirths were excluded, as were those patients who were discharged before the sixth day of the puerperium. As in the Cardiff study, "thromboembolism" was defined as any case of pulmonary embolism or deep vein thrombosis which showed signs definite enough to require the administration of anticoagulants. In the four years there were 14,754 cases for analysis, of whom 41.2% were lactating.

Table I shows the number and percentage lactating at six days. The cases are divided by mode of delivery into spontaneous vaginal, assisted vaginal, and caesarean section cases. The lowest percentage lactating (5.6%) was in those of high parity delivered abdominally. The total number of cases of thromboembolism was 78, giving a rate of 5.3 per 1,000 deliveries, a figure comparable to that reported in Cardiff.

Degenerative Tropical Neuropathy and Diet

Sir,-I read with great interest the report of a field survey by Dr. C. K. Osuntokun and colleagues (1 March, p. 547) in which the above relationship to cassava (manioc) consumption was suggested. It is interesting to add that manioc, a corruption of manihot by American and European usage, is of more recent arrival in Africa than the European, and was certainly unknown outside the Americas before the voyages of Columbus, not unlike the history of the introduction of tea and tobacco in Great Britain. As Jones further showed in his monograph, it became

\[
\begin{array}{|c|c|c|c|}
\hline
\text{Births} & \text{Mothers} & \text{Incidence} & \text{In} \text{UK} \\
\hline
5,595 (72.9) & 7,071 (92.9) & 2,088 (32.1%) & 14,754 (41.2%) \\
\hline
\end{array}
\]

The figures in brackets [1] are based on fewer than 500 deliveries.

\[
\begin{array}{|c|c|c|c|}
\hline
\text{Age < 25} & \text{> 25} & \text{Total} & \text{Age < 25} \\
\hline
\text{Lactating} & 9 (3.4) & 13 (4.4) & 22 (3.9) \\
\text{Not lactating} & 13 (4.3) & 23 (5.3) & 36 (4.3) \\
\hline
\text{Total} & 22 (3.9) & 26 (4.3) & 48 (2.7) \\
\hline
\end{array}
\]