Urodynamic studies show a high prevalence of unstable bladder activity in such patients but no consistent abnormality.1-4

About 15% of children have enuresis at 5 and about 2% at 16.1 Both sexes are equally affected among these young adults, but three distinct groups may be identified. Firstly, there are those who have only nocturnal enuresis: they are likely to be dry by age 25. Secondly, there are those with the enuretic syndrome: they have diurnal frequency, urgency, and urge incontinence as well as enuresis. The third group with recurrent enuresis are those who have relapsed after a variable period of being dry. In these second and third groups symptoms may persist for years and perhaps for life. One study of 65 consecutive adults with enuresis showed that 13 had only nocturnal enuresis, 36 the enuretic syndrome, and 16 recurrent enuresis.4 Most of the patients were under 30, and those who still had symptoms at 25 were likely to continue to have them.

As enuresis is a functional disorder examination of the patient, microbiological examination of the urine, and an excretion urogram will not show any abnormality. The functional bladder capacity may be reduced, but this will be shown only if the patient keeps a careful record: over one week he should record the volumes of urine voided and the episodes of incontinence. This simple exercise is often neglected, yet it provides useful information for the doctor and feedback for the patient. Few adults know how much their bladder holds or how much urine they produce during a night’s sleep.

Many treatments are available: conditioning techniques such as bladder drill;6 drugs such as tricyclic antidepressants, anticholinergics, and desmopressin; and, finally, for selected cases operative procedures such as bladder transection9 or enterocystoplasty.10 Ideally management should follow a rational sequence, but in practice this plan is often complicated by the psychosocial aspects of the condition.

We are now doing better at treating patients with urinary incontinence. The multidisciplinary Association of Continence Advisers was founded in 1981, and a report in 1983 from the King’s Fund has encouraged public education on incontinence.11 A report last year from the Royal College of Physicians suggested that all health districts should have a continence service,12 and continence nurse advisers have now been appointed in many districts. An adult with enuresis who has not responded to treatment needs the support of such continence services.

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non-smokers, and smoking probably has an additive rather than synergistic effect. Lymphoid infiltration of the mucus glands of the airways and the salivary and lacrimal glands may lead to the triad of dry cough, dry eyes, and dry mouth in Sjögren's syndrome. More serious effects on the airways include condritis of the tracheal rings in relapsing polycondritis and obliterative bronchiolitis in rheumatoid arthritis.

Pulmonary vascular disease may cause some of the more unpleasant complications of the connective tissue diseases—pulmonary hypertension, pulmonary haemorrhage, and thromboembolic disease. Pulmonary hypertension is a feature of scleroderma and of systemic lupus erythematosus, and pulmonary vasospasm induced by cold may be associated with Raynaud's phenomenon in scleroderma—but the evidence that this is the cause of the pulmonary hypertension is not convincing. A link has been suggested between pulmonary hypertension in systemic lupus erythematosus and antibodies to negatively charged phospholipids (antiphospholipid antibodies), and these antibodies are correlated with thrombosis and platelet hyperreactivity. Again no causal relation has been established between antiphospholipid antibodies and pulmonary hypertension.

Some patients with apparently isolated pulmonary disease may have connective tissue diseases. Patients with cryogenic fibrosing alveolitis may have hyperglobulinaemia and antinuclear antibodies, a combination which has been associated with Raynaud's phenomenon and digital vasculitis. Similarly primary pulmonary hypertension affects mostly women of child bearing age—that is, the same group who suffer from connective tissue disease—and Raynaud's phenomenon, hyperglobulinaemia, and other features of systemic lupus erythematosus are more common in patients with this disease than in the general population.

Acute pulmonary and pleural inflammation often respond well to steroid and cytotoxic drugs, but severe irreversible airways obstruction, pulmonary fibrosis, and pulmonary hypertension usually respond poorly, although a trial of treatment should be attempted.

Infection, drug reaction, and malignancy should all be considered in patients with connective tissue disease. Pulmonary shadows in patients with systemic lupus erythematosus are often caused by infection, and the diagnosis of systemic lupus erythematosus pneumonia should be made by exclusion. Solitary pulmonary nodules should always be fully investigated. Both disease and treatment may increase the risk of opportunistic infection, and bronchoscopy and needle biopsy are commonly indicated. Even open lung biopsy may be necessary to make a diagnosis.

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Christ Church conference on postgraduate education—25 years on

The Christ Church conference of 1961 chaired by Sir George Pickering led to one of Britain's most successful experiments in postgraduate medical education. Within 10 years postgraduate centres had been established in most district hospitals and honorary clinical tutors had been appointed from among the consultants to oversee education for all local doctors and dentists. A striking feature was the enthusiasm with which local communities—doctors and laymen—responded to requests for money and facilities.

The overwhelming impression of the recent follow up conference, held appropriately at Green College, Oxford, was that complexity, confusion, and uncertainty had replaced the clear sighted objectives of the early years. While the necessity for postgraduate education is accepted, awkward questions remain. What is the evidence that it is a good thing? Is it value for money? Are its methods sufficiently evaluated by audit and peer review? Are the people who provide it skilled in educational techniques? And perhaps most difficult of all: How are the conflicting requirements of the National Health Service (service to patients), the General Medical Council, the royal colleges and faculties, and the universities (education and training of doctors) to be reconciled?

A complex educational bureaucracy, unintelligible to outsiders, preserves the status quo by deferring to vested interests and accepting rigid requirements for training. A hospital, for example, may be visited by inspecting teams from the university to look at the preregistration year, the royal colleges and faculties to look at senior house officer and registrar posts in medicine, and specialist advisory committees to look at senior registrar posts. Each team makes independent recommendations to its parent body. Such visits are expensive and time consuming if carried out properly. How much more sensible it would be to have a single national inspecting body, as in North America and Australia, that would accredit hospitals rather than posts and consider service provision as well as educational facilities.