generation Wolf lithotripter also confirm this. At three months 35% of patients were completely free of stones. At six months the proportion rose to 56%, with a further 29% having fragments less than 2 mm in diameter which can be expected to pass.

It is just over six years since the first patients underwent extracorporeal shock wave lithotripsy, and with this fairly short follow up the rate at which stones have reformed in patients with residual fragments has been no greater than 10%, which is in line with results from open surgery. Lithotripsy not only has a better long term outcome than is reported by Mr Mays and others, but in patients who require future treatment, complications are rare. This is important both for the patient and for the second generation lithotripters, with which anaesthesia is not required.

Further points that should be made include the failure of the authors to relate size of stone to position. Had they done so they would have found more specific subgroups of patients in whom residual fragments can be found more commonly; for example, a 20 mm diameter stone in the renal pelvis will take out the patient over 20 months. Smaller upper caliceal stones in terms of residual fragments.

We do not argue that residual fragments remain after lithotripsy. It is our belief, shared by urologists throughout Europe and the United States, that first fragments will eventually pass procedures when still present are of little consequence. It is also difficult to understand the data from the 13 centres which report percutaneous nephrolithotomy was carried out. Our experience at St Peter's Hospital illustrates how these results will have been undertaken under the care of one consultant, is that complications, although uncommon when compared with those after open surgery, occur many more often than are recorded in the study, and would imply that only simple cases of complications have been described.

We await the results of the same group comparing the costs and quality of life in patients having lithotripsy and nephrolithotomy. Costings from our own unit show that the cost of lithotripsy is almost half that of nephrolithotomy for an equivalent case.

In our own institution, which has managed over 300 patients over the last 20 years, in our own surgery, nephrolithotomy, and lithotripsy, there is no doubt of the non-traumatic efficacy of lithotripsy. It is painless obvious from this paper that the authors with the exception of Mr Palfrey have had no hand experience of the complications resulting from open surgery. If only 10% of their patients were free of stones by lithotripsy then the lack of surgical trauma and morbidity would surely make the procedure worthwhile even though the expense.

We would like to ask the authors, in particular Mr Palfrey, which technique they would choose if they were faced with a renal stone themselves. We do not think that considerations of cost would hold large in their decision.

In summary, we think that this article was a counterproductive exercise by non-clinicians who are not confronted with the day to day management of renal stones. If lithotripsy is as inferior as they imply should the St Thomas's Lithotripter Unit continue to operate? Our answer is yes.

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1 Palfrey ELH, Bultitude MI, Challah S, Pemberton J, Shute-

2 F. Rassweiler, J. Bob P, Kallert R, Miller K. Differentiated approach to staghorn calculi using extracorporal shock wave lithotripsy and percutaneous nephro-


* This correspondence is now closed. – Ed, BMJ.

Children and apathetic

I applaud Dr Naomi Richman's opening sentence in her Personal View on South Africa, "The abuse of even one child in this country, especially if this leads to death, causes us concern," but thereafter her article is onedid (13 August, p 495).

She makes constant reference to the physical and mental abuse of children, implying that this abuse occurs only in South Africa. As much as she feels strongly about what is happening to children under apartheid why does Dr Richman not feel equally strongly about the many children in the African National Congress who are also terrorised and tortured in detention camps if they do not follow party policy?

How banning is going to improve or solve a problem I have yet to understand. The South African government speaks severe criticism every time it bans anyone it does not wish to see or hear. What is the difference between its policy and the one she advocates? Is it the policy of radicals from both the left and the right to prevent people of different opinions from voluntarily and boycott support only radicals. Most people are reasonable and wish to be given the chance to live.

Why punish those who are trying to build bridges between the races? Many doctors in South Africa play an important part in ensuring the health and welfare of each part of the population despite many impediments placed on them. Why should they be punished? Boycotts and bannings will certainly not help blacks, and I believe they suffer enough without having further hardship inflicted because people living 10 000 miles away believe they can play God.

A few weeks ago a bomb was placed in a crowded multi-racial restaurant one kilometre from where I was consulting rooms. I arrived within three minutes of the explosion with hundreds of paramedics, both black and white. The victims were mostly children spending a morning enjoying their favourite food and had belonged to all racial groups. The most severely injured child, who died five hours later and whom we spent some time resuscitating even though her arms and legs had been blown off and she was black from burns, could only complain of how cold she felt. I discovered only the next day that she was white. What, may I ask, is the difference between those children's torture and suffering and that of those in detention? Will my colleagues ever come to see me in the KED? If we follow Dr Richman's policy perhaps we should ban Catholic doctors unless they publically denounce the Irish Republican Army or Iranian doctors for not standing up to Ayatollah Khomeini for his persecution of the young of his country in his border war.

If Dr Richman wants to solve the problems in southern Africa she should stop believing that every white is bad and every black is good. South Africans need help and guidance on how to live together. If she, as a British doctor, wants to play a part in countering the hardships of apartheid she should come here and help us in overcoming our problems.

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Points

Depression resistant to tricyclic antidepresants

Dr Philip Smeth (Department of Psychiatry, St James's University Hospital, Leeds LS9 7TF) writes: In his editorial Dr P J Cowen (13 August, p 435) states that admission to hospital is usually necessary for patients requiring electroconvulsive therapy. This is incorrect,

for electroconvulsive therapy, like any other procedure requiring brief anaesthesia, may be given to outpatients, which facilitates using this effective treatment and thereby relieves the suffering and considerably reduces the cost of treating this common disorder. At this hospital we have treated many outpatients with electroconvulsive therapy for many years without mishap. Many psychiatrists might, however, be deterred from using electroconvulsive therapy in outpatient departments by the possibility of mischance due to the lack of adequate information being given to patients and their relatives. We realised this and printed a clear instructional sheet, which is given to patients and their relatives at the time of signing the consent form. The instructions were approved by the hospital anaesthetist and the Medical Protection Society. If any psychiatrist wishes to see the instructional sheet I shall be pleased to send a copy free of charge.

Injuries to the eye

Dr Anthony G Freeman (Swindon, Wiltshire) writes: Messrs A R Elkington and P T Khaw mentioned some of the important causes of direct trauma to the eye (9 July, p 122). They rightly emphasised the compli-

cations of receiving the direct impact of a small object, such as a squash ball, but they did not mention that various types of cork or stopper have produced severe corneal injuries. They are fairly specific only to champagne cork injuries. Such injuries occur not only in those of us who still like to celebrate

deydays and holidays in the traditional manner but also in professional barmen and skilled butlers. I have seen a number of cases, whether it was by forceps or other methods. Archer and Galloway pointed out that a champagne cork from an upright bottle can reach a vertical height of 40 feet after ejection. The cork thus strikes the eye at a velocity of 45 feet per second, so a cork travelling at this speed could reach the eye from less than two feet away in less than 0.05 seconds. The blink time for adults is about 0.1-0.2 seconds so the cornea would receive the full impact of the cork. Great care must be exercised in opening these bottles. The Consomme Interprofessionel du Vin de Champagne has given certain guidelines which are worth repeating. A napkin should be held over the cork and the neck of the bottle when the wire cage is being undone. The cork is easily cased off with the bottle pointed away from the face. There should be no "pop" but merely a sigh. For serving the champagne the handbook recommends, "White gloves may be worn but are not essential."


Living with a stoma

Dr Bryan Lask (Hospital for Sick Children, London, WC1N 3JH) writes: The editorial by Ms Kay Neale and Mr R Phillips (30 July, p 310) was a useful reminder of the many complications of stomal surgery. It was sad, however, that the authors omitted to mention the use of colonic irrigation, a simple technique that renders most colostomies continent. Most doctors seem to be unaware of this invaluable and easily performed technique, which makes life so much easier for colostomists. It is to be hoped that doctors who care for patients with colostomies will make a point of investigating the suitability of colonic irrigation in each case.