patient facilities for addicts in the London area are certainly inadequate to meet the demand that will be created when the regulations forbidding private prescribing come into operation.

Recent discussion[3 4] in the *B.M.J.* of British and American experience has made it clear that the best treatment for addicts is not yet agreed. If the Government really means to tackle the growing problem of drug addiction it must make money available to equip and staff treatment centres, which could then be used to assess the merits of different ways of treatment—the use of differing degrees of compulsion, the value of drugs such as methadone and cyclazocine, and the use of community-centred programmes. The profession has been assured[2] that the new regulations will not be brought into operation until there are adequate centres. It is equally important for the Government to show some practical evidence of its professed sense of the urgency of the problem by providing the money needed to cope with it.

Australian Doctors in Vietnam

The pressing needs of the civilian population in Vietnam for the benefits of modern medicine are apparent from a recent Australian study. A symposium on the work of Australian surgical teams there, reported in full in the *Medical Journal of Australia*,[1] provides a story which is both tragic and inspiring. It is tragic because of the amount of human suffering concentrated in Vietnam ; inspiring because of the help which these teams are bringing to that country.

Two problems in particular stand out: a primitive existing medical service which can provide only the most sketchy facilities—so that the disease picture is nineteenth-century or earlier—coupled with a large number of civilian casualties produced by all the refinements of modern warfare from napalm-charring to the multiple wounds of Claymore mines.

The bare outlines of the medical situation in South Vietnam are as follows. There is a population of about 15 million people, of which about 10% are refugees. The average life-expectancy is 38 years, and about one-quarter of infants born alive are dead before the age of 5. Causes of death include tuberculosis, pneumonia, malaria, typhoid fever, and the dysenteries. Other major diseases include cholera, plague, leprosy, and worm infestations. In December 1965 there were only 244 doctors available for the civilian population (180 of these were Vietnamese and 64 from other countries). The present proportion of doctors to population is 1 to 61,000.

Australia's assistance with financial non-military medical aid is second only to that of the U.S.A., and in addition since 1964 she has sent from Melbourne surgical and medical teams totalling 75 doctors together with nurses and technicians who work a three- to six-month tour of duty. At present there are 28 teams in South Vietnam from 13 countries, of which Australia provides three. Only three other countries provide more than one team, and these are Korea (7), the Philippines (5), and the U.S.A. (4). The United Kingdom has one paediatric unit at present serving in Vietnam.

The bare statistics provided by P. G. Large in this symposium give some idea of the amount of work to be done. In 15 months the Australian teams carried out over 4,000 operations, a total of 270 cases per month, of which three-quarters were major. About half the cases were emergencies, of which two-thirds were traumatic in origin. Individual case histories help fill in the background to these figures—children injured playing with a grenade, an amputation case arriving two days later with artery forceps still attached to the stump of the leg, a woman with a bullet wound involving the common carotid artery who travelled 36 hours and 100 miles (160 km.) to reach the hospital, and patients arriving with their wounds stuffed with tobacco.

The report from the plastic surgeon, John Snell, shows that there are only two civilian plastic surgeons in the whole of Vietnam, neither specially trained. Three Australian plastic surgeons have battled with the vast array of advanced deformity. The tasks of the nurses are also immense, as reported by Miss Susan Terry ; in provincial hospitals there may be three nurses to tend 500 patients.

Summing up the symposium, J. D. Villiers gives the three aims of these Australian teams: firstly, humanitarian, the care of civilian sick and wounded ; secondly, diplomatic, in that the teams are tangible evidence of Australia's concern for her less fortunate neighbours in South-east Asia ; and, thirdly, the training of Vietnamese personnel. A primary function of the team is to leave behind it a structure capable of continuing its work.

Disc Protrusion and the Bladder

It is well known that lesions of the lower spinal cord and the cauda equina may interfere with neurological control of the bladder. Congenital defects, trauma, pressure from neoplasms, and inflammatory conditions are responsible for most of the cases. The role of lumbar disc protrusions is less clearly defined, and a diagnosis of bladder dysfunction from this cause when the characteristic features of local muscular spasm and referred pain are absent might at first sight appear questionable.

In a recent report from the Mayo Clinic J. G. Love and J. L. Emmett[1] described three cases in which urinary retention was attributed to asymptomatic lumbar disc protrusions and in which normal function was restored by appropriate surgery. All the patients were women and somewhat fat. All had suffered from enuresis in childhood, but no other neurological factor had been suspected and neither physical examination nor myelography had shown any abnormality. At cystoscopy there was a large vesical residue, but suspicion was aroused by the absence of sensation on instrumentation and the lack of discomfort on further distension of the bladder. In each case the bladder was smooth and could expel urine normally through the cystoscope. Laminectomy was done to explore the filum terminale and in each case it revealed a protruded lumbar disc which proved to be the cause of the symptoms.

It is worth noting that all the patients were women. Urinary retention is relatively uncommon in women, except when due to gynaecological causes or cystitis, and it is prone to be ascribed to "hysteria." Clinical experience indeed suggests that in many instances the condition is transient and is permanently relieved by simple catheterization. But there are none the less some patients in whom dysfunction persists despite elimination of any urinary infection and treatment with cholinergic drugs. The usual management of these cases has been to carry out a limited perurethral resection of the bladder neck to relieve a hypothetical obstruction. It seems surgeons should now first investigate the termination of the spinal cord in more detail in such resistant cases.

[1] *Med. J. Aust.*, 1967, 2, 331.

[1] Love, J. G., and Emmett, J. L., *Mayo Clin. Proc.*, 1967, **42**, 249.