Wetting and Soiling

Sir,—We are concerned that there may be some misunderstanding of Dr. A. C. Woodmansey’s advice on the treatment of disorders of elimination in children (15 July, p. 161). Child psychiatrists tend to see a very biased sample of enuretic children and to a lesser extent of those with encopresis; this sample tends to be biased in favour of those children and families who show undue anxiety about the problem. To this extent and in the need to relieve the anxiety rather than resorting immediately to symptomatic treatment, we would fully agree with Dr. Woodmansey. Yet would we agree that in many cases it is unrealistic to anticipate biological maturity. However, there are many children in the community, and particularly those who attend their general practitioners and school or local authority enuretic clinics, who are not seriously disturbed but are merely worried, fed up, and self-conscious about the problem, which particularly handicaps them when they wake up away from home, as for example, when on holiday. We find that these children gain great confidence and esteem from successful symptomatic treatment—for example, by conditioning which may start at an early age.

There are families where the disorder of elimination has come to assume disproportional significance, and the disturbed family situation which may result requires careful investigation and management. Yet in these cases require more detailed physiologic investigation to exclude cases of faecal impaction and urinary abnormalities. It might be possible to argue with Dr. Woodmansey that the conclusion of the theory of the enuresis alarm as being aversive; in our practice few children see it as punitive and in fact find its use most rewarding. We feel that due weight should be given to this form of help rather than mere reassurance and a “wait and see” policy, which is hardly likely to appeal to mothers who have to wash and dry night wear and at least two sheets every day, year after year.—We are, etc.,

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SYLVIA DISCHE

Inner London Education Authority
Sunderland Comprehensive School
Brixton Child Guidance Unit,
London S.W.9.

1 Young, G. C., British Journal of Hospital Medicine, 1969, 2, 628.

2 Woodmansey, A. C., British Journal of Hospital Medicine, 1969, 2, 161.

Stirling Radiation Risks

Sir,—I read with interest your leading article (15 July, p. 130) on “Supersonic Radiation Risks.”

I feel I should point out an error. It states that “A mass miniature radiography chest x-ray examination on an old set may give 10 mrem... .” Mass radiography of the chest with old equipment could give an exposure of 1,000 mrem. With modern equipment this is frequently between 100 and 200 mrem. Of course, this is only to a portion of the body and if the gonads are not in the beam they only receive a few mrem or fractions of a mrem.—I am, etc.

J. VINCENTI
Eras Colne,
near Colchester, Essex

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Neurotic Dyspnoea

Sir,—I was specially interested in the feature “Second Opinion Please; Problems with Asthma” (1 July, p. 37).

We all from time to time meet patients whose confidence is severely shaken—in themselves, in their physicians, or in the treatment they are having. Three cases illustrate my point. A 72-year-old man had suffered from a coronary occlusion and was discharged on the usual treatment, including anti-coagulants. A few days after leaving hospital he complained of feeling very short of breath, but examination did not reveal any special finding to account for the dyspnoea, and to begin with he was reassured and told that the cause of the symptoms was undue anxiety concerning his condition. However, the dyspnoea continued and worsened. A few days later he had to be readmitted to hospital, where unfortunately about twelve hours he died.

A woman in early middle age of good mental stability and intellectual competence was short of breath. She had been particular short of breath for some time and could not explain why. Her case had been investigated by a number of doctors and no adequate cause for her shortness of breath had been discovered. She said to me “I suppose I must be getting neurotic.” There was nothing significant to find on physical examination and chest x-ray had been passed as normal. I was, therefore, not able to make any diagnosis, but did suggest as to the possible cause of the symptoms, and about three quarters of an hour later an incident occurred suggesting that my suggestion was right.

About a year ago I was concerned in the attempted resuscitation of a young woman of 19, who had been brought to the hospital unconscious. We were not able to revive her, and it is probable that death had occurred in the ambulance on the way to the hospital. It seems that the patient had been taken to her doctor by her parents because she had become extremely short of breath and after diagnose asthma she sent her to the local chest clinic for x-ray. About one minute after the chest x-ray had been exposed the patient collapsed and had to be rushed to hospital by ambulance.

In the first case necropsy showed that the patient had a pulmonary embolus. In the second case, not long after I had left the patient an attack of chest pain and a small haemoptysis occurred. She was put on anti-coagulants, her symptoms improved, and later she was able to return to work. In the last case there was of course a coroner’s inquiry and it was found that the cause of death had been pulmonary embolism.

Certainly small, and many large, pulmonary emboli do not cause pleural pain, and do not cause haemoptysis. It is possible that quite a large number are in fact

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