educating patients who have been perturbed. Finally, the cooperation of interested local general practitioners, whose skills in domiciliary terminal care are keenly appreciated, is fundamental. That teamwork and adequate endoscopic resources are essential in treating this challenging malignancy is obvious from our results and those of other gastroenterologists.

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¹ Gross E, Bancewicz J, Ingram G. Assessment of gastric cancer by laparoscopy. *Br Med J* 1984;288:1577.

² Ogilvie AL, Dronsfield MW, Ferguson R, Atkinson M. Palliative intubation of oesophagogastric neoplasms at fiberoptic endoscopy. *Gut* 1982;23:1060-7.

³ Pearson JG. The present status and future potential of radiotherapy in the management of oesophageal cancer. *Cancer* 1977;39:882-90.

SIR,—The operative mortality of 30% estimated by Mr Richard Earlam (23 June, p 1892) is, I believe, a true reflection of the work of the occasional oesophagectomist. It is a measure of the failure in Britain to train surgeons in this special problem and to organise the care of these patients in a hospital that has a fully trained surgical team and the ancillary assistance which these patients require.

As pointed out by Miss Mary Shepherd (14 July, p 114), a mortality of 33% is unacceptable and is vastly greater than that obtained in centres of excellence. Published mortality figures may not reflect the true position, as is emphasised by Mr R M Kirk,¹ but this theory is overcome by the work of Paris, who sent a questionnaire to 57 surgeons throughout the world who had special expertise in treating cancer of the oesophagus, asking for the mortality figures obtained in their units even though these figures had not been published.² The results of this study, which was carried out in 1976, showed that the overall mortality was 18%. This figure corresponds closely with the 14.3% recorded by Collis (1971),³ the 14.4% recorded by Gavrilu (1976),⁴ and the 18% recorded by Jackson *et al* (1979).⁵ In a review of a personal series (to be published in October) the overall mortality in 478 cases was 10.1%. In this series only those unfit for anaesthesia or who had extensive metastases were refused operation. No case was turned down as a bad risk because of age or concomitant disease. In a similar series Mannell (1982), using the same techniques as used in the Darlington series, reduced the overall mortality still further to 9.8%.⁶

The extremely low mortality figures of 1.2% recorded by Akiyama and his colleagues⁷ (one death out of 81 cases) and of 1.3% by Henry Ellis⁸ (three deaths in 149 cases) reflect the results obtained by highly skilled surgeons in highly selected cases. As such they are not comparable to the results recorded above.

The outstanding lessons to be learnt are that oesophageal surgery requires special individual personal training to selected surgeons and that the admission of cases of oesophageal carcinoma to centres of special skills should be encouraged if not organised. To attain these objectives the formation of an association of oesophageal surgeons is long overdue.

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¹ Kirk RM. Double indemnity in oesophageal carcinoma? *Br Med J* 1983;286:582-3.

² Paris F. Quoted by McKeown KC. In: Nyhus LM, ed. New York: Appleton-Century-Crofts, 1980:264.

³ Collis JL. Surgical treatment of carcinoma of the oesophagus and cardia. *Br J Surg* 1971;58:801.

⁴ Gavrilu D. *Aspects of oesophageal surgery*. Chicago, London: Year Book Medical Publishers, 1979. (*Current problems in surgery* 1979.)

⁵ Jackson JW, Cooper DKC, Guvendik L, Reece-Smith H. The surgical management of malignant tumour of the oesophagus and cardia: a review of the results of 292 patients treated over a 15 year period (1961-1975). *Br J Surg* 1979;66:98-104.

⁶ Mannell A. *Carcinoma of the oesophagus*. Chicago, London: Year Book Medical Publishers, 1982. (*Current problems in surgery* 1982.)

⁷ Akiyama H, Miyaxo H, Tsurumaru M, Hishimoto C, Kawamura H. Thoraco-abdominal approach for carcinoma of the oesophagus. *Am J Surg* 1979;137:345-9.

⁸ Ellis FH. Oesophagogastric carcinoma of the oesophagus and cardia: current risks and results. In: Watson A, Celestin LR, eds. *Disorders of the oesophagus*. London: Pitman, 1984:193.

Video as a teaching aid

SIR,—We agree with Dr M Afzal Mir and others (7 July, p 31) that "videotape demonstrations can be as effective as personal teaching." Dr Mir's study was with medical students; as part of a Scottish national research project we have shown this medium to be effective in teaching other professional groups and patients.¹

Forth Valley Health Board and Stirling University produced educational videos and evaluated their use in normal hospital, clinic, and surgery settings. A video showing urine glucose testing was shown to 11 diabetic patients. The patients then had to demonstrate the test, and their performance was scored objectively on a specially designed form. These patients' results were compared with those of 10 patients who had watched a nurse's demonstration, and there was no significant difference between the two groups. On another occasion 22 patients who regularly used a specific urine test were asked to demonstrate the test before and after viewing the video. Objective scoring of their performance showed a significant improvement ($p < 0.01$) after viewing.

We then found that video was equal to a demonstration by a trained nurse in teaching new skills to patients, nurses, and doctors and was also effective in reinforcing partial knowledge previously acquired. Video was better than poster demonstration and written instruction.

A later investigation of 86 patients in general practice showed that patients were extremely positive to this medium: 85% wanted videos to be used more in hospitals and surgeries.

Patient education videos have now been made available for use in general hospitals and some health centres within the health board area. Although an extremely useful medium, videos are not always appropriate and professional back up should be available to answer patients' questions. The style of teaching technique used in the videos is important as this can greatly affect both the amount learnt and the motivation of the individual to apply the information he has retained.^{2,3}

We should like to acknowledge the assistance of both patients and professional staff throughout this study and also the funding provided by the Scottish Health Education Group.

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¹ McEwan C, Fraser KJ. Videorecorded programmes for patient education. In: Bateman EC, ed. *Applied nutrition: 2 (Proceedings of BDA study conference 1983)*. London: John Libbey (in press).

² Baggaley J. *Psychology of the TV image*. Westmead, Hants: Gower 1980.

³ Coldevin GO. Experimental research in television production techniques and presentation strategies; and current directions. *Journal of Educational Television and Other Media* 1980;3:92-7.

SIR,—One aspect of the valuable study of Dr M Afzal Mir and others (7 July, p 31) merits further comment. Examiners used standardised scoring charts for rating clinical skills. Included in these skills was the examiner's "impression" of the student's "overall approach, style, performance and fluidity." Pioneered by Harden and Gleeson,¹ structured practical examinations of this type have been shown to be valid,² but there is evidence that the reliability of examiner rating is not satisfactory.^{2,3} Also, such appraisal of physical examination performance may not necessarily reflect student ability to evaluate the patient's physical state.^{4,5} (If the check list item "correct conclusion" in the study of Dr Afzal Mir and others refers to this ability it would be of interest to know whether individual student score on this item correlated with scores on items concerned with performance alone.)

Until the problem of marker reliability and the practical implications of a thorough and generally proficient observer rated performance are adequately resolved, in evaluating methods directed to the acquisition of diagnostic skills it is important to use tests that include measurements of the outcome as well as the process.

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¹ Harden RM, Gleeson FA. Assessment of clinical competence using an objective structured clinical examination (OSCE). *Med Educ* 1979;13:41-54.

² Newble DI, Hoare J, Elmslie RG. The validity and reliability of a new examination of the clinical competence of medical students. *Med Educ* 1981;15:46-52.

³ Gledhill RF. Factors affecting the reliability of an objective structured clinical examination (OSCE) test in neurology. *S Afr Med J* (in press).

⁴ Harper AC, Roy WB, Norman GR, Rand CA, Feigter JW. Difficulties in clinical skills evaluation. *Med Educ* 1983;17:24-7.

⁵ Gledhill RF. Evaluating clinical competence in students. *Lancet* 1983;i:595.

Uterine prolapse and urinary tract obstruction

SIR,—I want to add a note of caution to Dr J B Young and others' lesson of the week on uterine prolapse and urinary tract obstructions (7 July, p 41). I did not think that this problem was considered unusual, having seen several cases while working in Nottingham. On one such occasion I was flushed with success having "cured" a woman's anuria by replacing the procidentia and fitting a ring pessary. I was then asked by sister if I would care to perform the same "miracle" on another old woman with anuria and uterine procidentia who had had abdominal surgery.

After discussion we decided that the anuria was almost certainly postrenal in cause, and the prolapse was replaced with slightly more difficulty than in the previous case due to tissue oedema. Sure enough, urine started to flow, and I left the ward content with my two "miracles" for that day.

Later that evening while rehydrating ourselves after the day's trials and tribulations, we met the intensive care staff and were informed that the second woman had been relieved of the

need for medical miracles after a massive pulmonary embolism about three quarters of an hour after her proident was replaced. I think there is little doubt that a difficult replacement had not aided her postoperative course, although it had relieved her anuria.

Replacing a procidentia and fitting a ring pessary is basic medicine, and while a gynaecologist might be required in difficult or recurrent cases of prolapse, he should not be required for the simple case—as any general practitioner will confirm.

Finally, there are cheaper methods of assessing renal function than those listed at the end of the article by Dr Young and others. The teaching units may have the time as well as the staff and money to test all such women as suggested, but such a scheme in most district general hospitals would choke the radiography department with investigation requests and bankrupt us.

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SIR,—We were interested to read the paper on uterine prolapse and urinary tract obstruction by Dr J B Young and others (7 July, p 41) since we have seen this condition in three out of four elderly patients who presented to us with procidentia over the past two years. All four had third degree prolapse, but only three had radiological evidence of obstruction. Two of these patients were in their 70s, and the third was in her 90s. Surprisingly, there appeared to be no direct relation between the length of time the prolapse had been present and the degree of changes noted on radiological investigation.

Although all three had radiological evidence of renal tract obstruction, only one presented with acute renal failure and required dialysis. This patient died postoperatively. The two other patients, like most in previous reports,^{1 2} had normal renal function on biochemical screening. Intravenous pyelograms were ordered in these two patients because of this well known and important association, which was first reported over 150 years ago by Froriep.³

Although three patients under our care had procidentia, this complication can occur in association with first or second degree prolapse.² It is because of this and the fact that renal failure associated with this can lead to death that this condition is not to be regarded as benign.^{4 5}

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¹ Wosika PH, Maher CC. Prolapse of the uterus, hydro-nephrosis and hypertension. A probable sequence of events. *Am J Obstet Gynecol* 1939;38:684-92.

² Klemperer E. Gynaecological lesions and hydro-nephrosis. *Am J Obstet Gynecol* 1952;64:1232-41.

³ Froriep R. *Chirurgische Kupfertafeln*. Weimar: 1824.

⁴ Mueller-Henrich E. Prolapsus uteri causing hydro-nephrosis. *J Am Geriatr Soc* 1969;17:1055-63.

⁵ Wallingford AJ. The changes of the urinary tract associated with prolapse of the uterus. *Am J Obstet Gynecol* 1939;38:489-94.

The doctor and the child with learning problems

SIR,—I was much concerned on reading Professor Roger J Robinson's article (30 June, p 1937) to discover no reference to the child psychiatrist and only one (and that apparently as an afterthought) to emotional causes of

educational backwardness. Emotional causes are of primary importance far more often than are neurological ones and occur as secondary features in many cases where there is a substratum of organic disability. Failure to recognise this accounts for many of the failures of a purely educational approach, and all those likely to be consulted about backward children should be aware of this.

Psychological and emotional development are as important features of the history as is physical development, and where the family doctor does not have the time or expertise to elicit them referral to a child psychiatric department should be considered. It should also not be forgotten that learning problems may be an indication of family dysfunction as well as disturbance in the individual child, and for both these specialist psychotherapeutic help may be required.

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SIR,—I suggest that an additional phrase should have been inserted in the leading article by Professor Roger J Robinson (30 June, p 1937). He writes: "Finally, he [the general practitioner] can speak to the head teacher (with the parents' permission) . . ." This, surely, should read: ". . . (with the child's and the parents' permission) . . ."

A child can be caused needless, even though often unintentional, embarrassment if his permission has not been asked and given. If, as occasionally happens, the child queries the need for the school to be consulted, it alerts the doctor to be even more careful when talking with someone at the school to ensure that the child, perhaps a very intelligent boy with dyslexia, is not singled out and, for example, called without notice from the classroom to see the head teacher. He is already having problems with his peers. If the class teacher has not already spotted the problem, he or she is quite possibly not a person who is sensitive to the child's difficulties.

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SIR,—I find it disappointing that Professor Roger J Robinson has confined his remarks on the school medical officer to his last small paragraph. Today's school doctors are largely clinical and senior clinical medical officers with a specific interest in learning problems. Schools usually ask for assessment and help from their doctors early in the evaluation of these problems, and close working relationships should and usually do exist among doctors, educational psychologists, and school staff. Whereas there may well be a few general practitioners experienced in this subject it seems a pity not to emphasise the one group of doctors practising educational medicine.

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SIR,—I am concerned about the ways of managing children with learning difficulties proposed by Professor Roger J Robinson (30 June, p 1937). Having suggested both "masked school phobia" and "emotional causes" as possible aetiologies, he makes no mention of the

central role of the child psychiatrist in helping children with learning difficulties.

Learning difficulties crop up mainly in the first years of schooling. Important intellectual handicap is usually diagnosed long before children start school, and lesser degrees of handicap are identified by teachers with the help of educational psychologists. A few children may present as underachievers at a later stage of their schooling, and a few children have specific learning difficulties. The initial sorting out of these problems is mostly done by the school psychological service, which is well aware of the multiple aetiology of most cases.

In many areas the educational psychologist has close links with the child psychiatrist, either in a hospital based clinic (often working alongside paediatricians) or in a child guidance clinic. Most older school children who underachieve do not have intellectual or specific learning difficulties and have already been screened by school doctors for the important medical causes of failure to learn, such as deafness. These children should be referred by the educational psychologist or the family doctor to the child psychiatrist, who with his colleagues will be able to carry out a comprehensive assessment of all relevant medical, developmental, social, and emotional factors. Close links between the child psychiatrist and the paediatrician will ensure that uncommon and complex medical or developmental problems receive thorough investigation.

Emotional factors commonly have a profound effect on a child's ability to learn. In older children underachievement is commonly associated with emotional problems, both as cause and effect. This is, of course, the problem of the child psychiatrist, and I am surprised that Professor Robinson failed to indicate this important source of help for children with learning difficulties.

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SIR,—Professor Roger J Robinson provided some useful stepping stones in the murky waters of learning difficulties (30 June, p 1937). Other useful islands of knowledge were, however, not recognised.

Firstly, should not most doctors accept "that this is unfamiliar territory for which their training and experience has not equipped them" and after excluding physical disease refer to a child guidance clinic? Secondly, Professor Robinson points out that learning problems may arise from poor school attendance as well as from psychological, neurological, and emotional causes. Problems of school attendance may also, however, arise from psychological or emotional causes.¹ Learning problems may also give rise to secondary emotional and behavioural disorders.² So the doctor who ignores psychological and emotional factors in the child with learning problems does so at the child's peril.

Therefore, thirdly, it is not only school doctors who have been left out. The child psychiatrist is especially equipped to fulfil the medical role described by Professor Robinson. He can disentangle the developmental, interactional, and emotional components of these problems.³ He will also have ready access to the agencies which may be able to help the child with learning problems so is able to act as an effective advocate. It is essential to appreciate that if the emotional difficulties of the child are not being recognised and managed no amount