however, he seemed to completely change in personality from being a sleepy, placid baby to being a restless, demanding horror. He demanded feeds as often as hourly or two hourly—even through the night—and was very difficult to settle after feeds. Of course, I got the usual advice from my mother-in-law—“It’s your milk, dear, you haven’t got enough, or it’s too thin.” But I knew my physiology—all I had to do was let him suck, and Nature would do the rest. Nature did not.

With increasingly sore nipples and a baby continually screaming for something—apparently hungry, although he was rapidly gaining weight—I began to yearn for the simplicity of a bottle. At least I could then see what he had taken, and would know whether he was hungry or just bad tempered. The deciding point came after eight weeks of what can only be described as a nightmare, when my husband had to go to Malta on business, and I could accompany him. The decision was either to stay at home and battle on with the breast-feeding or to wean him on to a bottle, leave him with my mother, and go to sunny Malta for four days. Needless to say, the latter won and I have never regretted it.

I returned to my difficult baby with renewed energy, and I needed it. The change to bottle feeding had not altered my infant’s behaviour in the slightest—but it had altered mine. He still screamed all day long, but I no longer bared a breast at each scream but rather took him out for a walk, or carried him around strapped to me in a sling, as I knew from his milk consumption that he was unlikely to be hungry. I also discovered a new sense of freedom—I could go out shopping and leave my husband to feed him, and I could plan my return to part-time general practice. Night feeds also could be shared out, and my husband rapidly started to develop a relationship with his son which before had been totally absent.

It was five-and-a-half months before my child’s behaviour improved, and now, at almost a year, he is a delight. I have learnt many lessons from this experience—I still believe that “breast is best,” but I realise that in some situations bottle is more suitable. I feel that in our enthusiasm to promote breast-feeding it is important not to invoke a feeling of guilt in our patients who, like me, fail to breast-feed.

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Enuresis

SIR,—With reference to your leading article (17 March, p 705) and the article by Dr A J Cronin and others (p 722), if enuresis is treated as casually as you suggest, it shows little understanding of its main cause. If the child is otherwise normal the cause of wet beds is a small bladder capacity. If you take the trouble to ask the mother to measure the amount of urine the child can produce after holding on as long as possible you will find that there is a very small capacity. The treatment of enuresis is to increase that capacity. If this is done the condition cures itself. My normal policy is to get the child over the next school holiday to have a drink every time he passes a tap and to hold on five minutes after it starts to hurt. Within two weeks or so the problem has normally solved itself. The condition is caused by mothers and grandmothers who, on seeing the child naturally squirming at play,

say, “Go and wee before you wet yourself.” This results in a small bladder and a wet bed. Bells, buzzers, and drugs are very rarely required.

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Respiratory obstruction by epiglottitis

SIR,—I read with interest the report by Mr M Hardingham and Dr P N Young (4 August, p 309) of respiratory obstruction by the flaccid epiglottis, and their comments on the phenomenon. A similar case illustrated my report¹ on the fiberoptic laryngoscope as a “steerable guide-wire,” rather than as an optical instrument, for difficult or trauma cases.

This patient had attempted suicide by cutting his throat with a pair of scissors, resulting in a narrow wound penetrating the thyrohyoid membrane and amputating the epiglottis. The epiglottis, held only by mucosal strips, had impacted over the laryngeal inlet, while the patient breathed through the neck wound. Conventional oral intubation with topical anaesthesia was possible only by means of the extreme manoeuvrability of the fiberoptic laryngoscope, while the patient breathed via an endotracheal tube through the neck wound.

There was structural rather than functional damage to the epiglottis in this patient, so that patients with both respiratory obstruction and neck wounds may be doubly at risk—which emphasises the dangers of inexpert anaesthesia mentioned in the report.

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¹ Davies, J R, *British Journal of Anaesthesia*, 1978, 50, 511.

Travel and health risks

SIR,—Professor Brian Macgrath’s suggestion (18 August, p 443) that the DHSS printed warnings against malaria be enclosed within travellers’ cheque folders is admirable enough, but surely as a week’s prophylaxis against malaria costs less than half a penny (pyrimethamine 25 mg) might it not be more effective for airline stewardesses to hand them out before flights through endemic areas instead of the customary glucose sweets?

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Measles and vaccine protection

SIR,—Dr G A Jackson’s survey (4 August, p 332) of measles in children who had been vaccinated against the condition failed to take into account the population at risk: the number of children susceptible to measles (having no history of measles and being exposed to the possibility of infection) who were in the specified area during 1978. If that number were 1470 and they were vaccinated and then exposed to infection with measles the fact that 147 developed the illness would indicate a protection rate by the vaccine of 90%.

Without the number of susceptibles, the conclusion that the vaccine had lost potency is more than these data will support—a point

that is well illustrated by Canadian workers in WHO’s *Weekly Epidemiological Record* (1979, 54, 210).

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Unusual manifestation of hypocalcaemia

SIR,—As Dr K Graham and others have recently pointed out (2 June, p 1460), the clinical manifestations of hypoparathyroidism in the elderly can be atypical. I would like to draw attention to an unusual physical sign of hypocalcaemia in an elderly person.

The patient, an 81-year-old man, had been confused and restless during the three weeks before he was brought into hospital. On admission, he was disorientated and uncooperative. He had a marked dorsal kyphosis and the head was stretched forward. The trunk was so rigid that his head and neck did not touch the pillow when he lay on his back. Ankylosing spondylitis was suspected but there was no x-ray evidence for this. Laboratory investigations showed: serum calcium 1.25 mmol/l (5.0 mg/100 ml); phosphorus 2.8 mmol/l (8.5 mg/100 ml); alkaline phosphatase 3.7 Bodansky units; urea 3.9 mmol/l (20 mg/100 ml); albumin 36 g/l; globulin 28 g/l. After treatment, the calcium rose to 2.2 mmol/l (8.8 mg/100 ml), while the patient became fully conscious; his back and head assumed a normal posture and the spasticity disappeared. Idiopathic hypoparathyroidism was diagnosed.

There have been several reported cases of idiopathic hypoparathyroidism presenting with a clinical picture reminiscent of ankylosing spondylitis.^{1,2} In these cases, however, there were paraspinal calcifications on the radiograph and the condition was not reversible when the serum calcium returned to normal.

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¹ Adams, J E, and Davies, M, *Postgraduate Medical Journal*, 1977, 53, 167.

² Chaykin, L B, Frame, B, and Sigler, J W, *Annals of Internal Medicine*, 1969, 70, 995.

Chronic ambulatory peritoneal dialysis

SIR,—I read with interest your leading article (28 July, p 229) on chronic ambulatory peritoneal dialysis. May I draw your attention to two points?

The correct name of the technique you described is continuous ambulatory peritoneal dialysis or CAPD. By describing it as chronic you miss one of the major points of this technique—that is, it is continuous, which is a unique characteristic of this treatment.

The continuous ambulatory peritoneal dialysis was first described by Popovitch and his colleagues in 1976, as you have mentioned, but these authors were using dialysate in glass containers, resulting in a high incidence of peritonitis. The technique that you describe in your editorial in which “while the dialysate is in the peritoneal cavity the plastic tubing set and the bag are folded into a small container which is held around the patient’s waist” is the Toronto Western Hospital technique for CAPD, which was first presented at the meeting of the American Society for Artificial Internal Organs in 1978.¹ Using this technique we have now trained 95 patients and our

present infection rate is one episode every nine patient months.

Finally, I would like to add that one of the major advantages of this technique is that it is a dialysis treatment which does not require a machine. This has been appreciated especially by those patients who have been converted from intermittent peritoneal dialysis or hemodialysis to CAPD.

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¹ Oreopoulos, D G, et al, *Transactions of the American Society for Artificial Internal Organs*, 1978, **24**, 484.

Money and medicine

SIR,—Professor Rudolf Klein's commentary (21 July, p 220) is an interesting contribution to the annual pay struggle that exercises successive ministers of health and the medical profession in spite of the interposition of the Review Body. While I would welcome his facts and not argue with them, his views adhere more to the "mediaeval theologians" approach to a "just wage" than to the climate of today.

Society has regrettably become besotted with unsocial hours, a concept not introduced by doctors or nurses. My wife works Sundays as a midwife on time-and-a-half, but the domestic working with her is on double pay. Does Professor Klein really justify this because my wife reputedly likes her work and the domestic is in servitude? Junior doctors work many unsocial hours but their overtime pay is well below their standard rate—a state of affairs surely incomprehensible to most union members. Consultants remain "on-call" as part of their total commitment, and recall fees, agreed on four years ago, remain unfunded. When the Royal Commission on Doctors' and Dentists' Remuneration laid down its guidelines in 1960 the distortions created by the unsocial hours philosophy hardly existed, and the comparison of the medical profession with other professions, working few, if any, unsocial hours, urgently needs revision.

We still live in a free society and doctors have to pay the going rate for other people's services and commodities. In the real world of private enterprise a doctor has to pay a minimum call-out fee of about £10 for somebody to fix his television, yet most general practitioners charge about £5 for a private visit because they consider this more advantageous than losing the patient to the NHS. Another cause of anguish to doctors must be their total inability to obtain the quality of service from others that society demands from them. If the skills displayed by garages had been perpetrated by the medical profession we should all have been sued into oblivion by now.

Professor Klein appears to favour financial enslavement of a profession because there is a glut of those wishing to enter it. I think many students would willingly have gone into the other sciences had there not been a world recession and no market for their skills. Architects have suffered during recent times, but senior accountants, actuaries, barristers, solicitors, architects, surveyors, and engineers can all delegate work and derive personal income from it and when business is good they prosper greatly. Surely the selection, training, responsibility, and skills required of the professions must be taken into account and gain preference over job satisfaction, which is subjective and nebulous.

If Professor Klein seeks to regulate medical pay by supply and demand then he must admit that UK doctors in the NHS today are paid well below the free enterprise rate (the same issue of the journal carries an advertisement for an anaesthetist in Holland offering £25 000 a year plus single accommodation).

Differentials in society at large are changing and if the present trend continues the country will get the mediocre doctors and university teachers it deserves and is willing to pay for. Professor Klein's philosophy did not do much good for industry under Labour, and the new tax cuts are an attempt to get quality and not quantity back instead of an overdraft, frustration, and the search for emigration.

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Doubtful epilepsy in childhood

SIR,—Your editorial of 7 July (p 1) was well named and, with few changes, would cover this difficult ground for patients of all ages. Neurologists, like paediatricians, would agree that the distinction "between epilepsy and non-epilepsy" is sometimes impossible. No matter: the best of all investigators, time, brings the inexorable answer. How strange that you lost patience at the very last sentence but one and surrendered your clinical sense to a machine: "Thus headaches, vertigo, and abdominal pain may occasionally remain unelucidated until an EEG is performed."

Even the references betray you. Swaiman and Frank¹ described six children with paroxysmal headache, none of whom had had any episode of impaired, let alone loss of, consciousness although four of the six had spikes or spikes and waves in their electroencephalograms. To argue that such an EEG diagnoses epilepsy in these children because a similar pattern occurs in the EEG of another child with undoubted epilepsy is to fall into the logician's trap of the fallacy of the undistributed middle.² Nor should epilepsy be diagnosed because their headaches went away when the doctor prescribed phenytoin. Does anyone diagnose epilepsy because trigeminal neuralgia, the tonic spasms of multiple sclerosis, or toothache are relieved by an anticonvulsant?

Eviatar and Eviatar³ found that half of a group of 50 children with bouts of vertigo were epileptic. This was not altogether unexpected: gyrate epilepsy is well known; some say that it caused Julius Caesar's falling sickness. Eleven of their patients had unquestionably major fits, attacks with vertiginous prodromata "culminating at times in a tonic or tonic-clonic generalised seizure." Fourteen others had giddy spells with headache and vomiting which might progress to "loss of postural control and loss of consciousness with or without hypertonicity." Despite the spike and wave patterns in their EEGs, despite even the minor twitchings and drooling and loss of speech sometimes seen, some doubt must remain that these were truly epileptic attacks and not just syncopal episodes after vertigo—of whatever cause—accompanied by the occasional myoclonic jerk.

Papatheophilou et al⁴ studied 50 children with recurrent abdominal pain and re-examined the 14 respondents from an equally sized follow-up group in the hope of "clarifying some of the above conflicting findings in the literature." The low yield of cases with epilepsy

—one from each group and two others with photosensitive epilepsy—was a warning against twisting any human frailty into the tidy categories of limbic-lobe and complex partial epilepsy. This is what they wrote: "It seems to us that only in a very small proportion of children is recurrent abdominal pain or 'periodic syndrome' an epileptic phenomenon and that the finding of 'abnormalities' in the EEG, other than spikes or spike and wave, should not be taken as evidence of epilepsy." Please note also that they call spikes and spike and wave evidence of epilepsy and do not equate the electrical sign with diagnosis.

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¹ Swaiman, K F, and Frank, Y, *Developmental Medicine and Child Neurology*, 1978, **20**, 580.

² Fowler, H W, *A Dictionary of Modern English Usage*, 2nd edn, revised E Gowers, p 662. Oxford, Clarendon Press, 1965.

³ Eviatar, L, and Eviatar, A, *Pediatrics*, 1977, **59**, 833.

⁴ Papatheophilou, R, Jeavons, P M, and Disney, M E, *Developmental Medicine and Child Neurology*, 1972, **14**, 31.

* * * To elucidate means "to throw light on." To say that the EEG may occasionally elucidate a clinical problem is not the same as saying that it proves a diagnosis of epilepsy. Dr Wells appears to have ignored the last sentence of the leading article: "Nevertheless the mainstay of diagnosis in the paroxysmal disorders remains the doctor's ability to take and analyse the patient's history and assess his symptoms in the context of his psychological make-up." We believe as firmly as does Dr Wells that the EEG, like all laboratory investigations, must be assessed critically by the clinician.—ED, *BMJ*.

Celtic and non-Celtic nostalgia

SIR,—Dr Dewi Davies's charming piece on nostalgia (18 August, p 433) includes mention of *The New Oxford Book of Light Verse*. Its editor, Kingsley Amis, chose a particularly good sample of Celtic nostalgia in a verse by Wynford Vaughan-Thomas, now with us here in Pembrokehire. It is called "*Hiraeth in N.W.3*" (*hiraeth* is Welsh for nostalgia). It begins:

"The sight of the English is getting me down,
Fly westward my heart from this festering town . . ."

and ends:

"Glorious welcome that's waiting for me,
Hymns on the harmonium and Welsh cakes for tea,
A lecture on Marx; his importance today,
All the raptures of love with a Bangor B.A."

When Dr Davies does come home to these parts, he will find that my next-door neighbour grew up with him on the next farm—also having spent a lifetime in south-east England.

So—Croeso.

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Reduction of catheter-associated sepsis in parenteral nutrition using heparin

SIR,—We read Mr M J Bailey's study (23 June, p 1671) with interest and were impressed by the reduction in the incidence of infection. However, we felt it important to draw attention to an effect of heparin, even at low dose, which he does not discuss. We have shown that through its ability to increase lipoprotein