Of 200 consecutive children or young adults with nocturnal enuresis I found only 2 who appeared not to have had a single dry night. In other words, true "primary" enuresis is exceedingly rare and the usual situation is one of "intermittent" nocturnal enuresis.

I agree with Mr Hindmarsh that the term "recent-onset enuresis" or "secondary" enuresis is not very helpful. Its incidence, association and management will depend on the period of dryness that is demanded before the person is labelled as having "onset" enuresis. For instance, if a period of 12 months' absolute dryness is demanded the number of persons with onset enuresis will be small. If a period of only three months is demanded, the number with such onset enuresis will be quite large.

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"Lecture Notes on Medical Statistics"

SIR,—The point that has got lost in this "wordy warfare" (23-30 December, p 1783; 13 January, p 123; and 27 January, p 263) is the nub of my criticism (9 December, p 1631), which was contained in the words "the statistics needed by the intending clinician or medical researcher [is] different from that required by the intending statistician." Incidentally, reviews are signed because they are only the *opinion* of their authors.

May I cite two examples of the increasing concern with what statistics doctors and other medical writers do know? Firstly, there was a meeting last year in Lexington, Kentucky, organised by the Biometric Society under the title "Should there be Statistical Guidelines for Medical Research Papers?"¹ Secondly, this coming April a meeting is to be organised by the Royal Society of Medicine's section of medical education, in conjunction with the Association for Medical Education, under the title "Teaching and Learning Statistics in Medicine," at which your associate editor is delivering the first paper.

My opinion is that rehashing first-year statistics courses and spreading a few medical examples around the text is not the right way to educate medical students statistically. But it is only my opinion.

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¹ *Biometrics*, 1978, **34**, 538.

Phantom limb pain and propranolol

SIR,—Your excellent and comprehensive leading article (9 December, p 1588) has prompted me to share my observation with your worldwide readership.

Case 1—In August 1977, a 69-year-old man was admitted with diabetic ketoacidosis, diabetic angiopathy and neuropathy, coronary heart disease, and Gram-negative septicæmia. He underwent below knee amputation for gangrenous toes of the right foot. He was discharged home after a stormy and eventful stay in the hospital. He was then plagued with "phantom limb" pain. Analgesics prescribed by his family physician did not improve this condition. Propranolol 40 mg/day was added in his regimen to control his hypertension and angina. From that time not only did his cardiovascular status improve but the phantom limb pain also disappeared. After propranolol had been withdrawn because of cardiogenic shock and

heart blocks following recent myocardial infarction, he started having severe phantom limb pains.

Case 2—In October 1977 a 69-year-old man underwent below knee amputation because of gangrenous toes of the left foot. He had survived two myocardial infarctions (1957 and early 1977) and was diabetic and a heavy smoker. He developed attacks of stabbing and lightning pains in the stump lasting for hours and days. Analgesics offered no solace. Propranolol 40 mg daily was added in the regimen for angina pectoris. He never complained of this "wretched pain," as he called it, while on propranolol.

These two patients were incapacitated with pain but lived happily after taking propranolol. The second was very happy that he could manage to use his artificial leg. I feel it is worth reporting the usefulness of propranolol in these two "mentally and physically crippled" patients who managed to cope better with their lives.

Further investigation of this observation should be undertaken because anything which mitigates the lot of the patient with phantom limb pain is very much worth while.

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1918 influenza epidemic

SIR,—I remember as a house physician in Queen Alexandra Hospital, Cosham, during an influenza outbreak in, I think, 1957, seeing a middle-aged man, admitted in a moribund condition from his general practitioner's surgery, with a stench so fearful that I could only examine him for some seven minutes at a time. At the subsequent necropsy one lung was green and gangrenous with multiple small abscesses forming.

I do not know if similar pathology occurred in the 1918-8 outbreak, but if it did it might account for the stench referred to by Minerva (16 December, p 1722).

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"Helping with Health"

SIR,—Your reviewer TS in "Medicine and the Media" (13 January, p 118) appeared puzzled by the intended audience for "Helping with Health," yet he diagnosed it quite correctly. The series was intended for all professional health workers and this was clearly announced at the beginning.

It will be repeated in July (Sunday afternoons, Radio 4, VHF) and will be followed early next year by a related series on health education, on the prevention of illness, which, like the recent series, has been developed in consultation with the Health Education Council (and many others).

When professionals talk to professionals jargon sometimes crops up as a form of shorthand, though we don't encourage it.

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Abortion and the NHS

SIR,—The impression gained from the paper by Dr F G R Fowkes and his colleagues (27

January, p 217) is that the writers are in favour of abortion on demand. It suggests that the NHS figures show "discrimination" against applicants who are single; surely many of these are not covered by the terms of the Abortion Act?

One of the most emphasised recommendations of the Lane Report was the need for better facilities for counselling. No comment is made on this in the article.

Does not the low rate of sterilisation in the private sector suggest that there is no incentive to kill the goose that lays the golden eggs?

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Who does the surgery?

SIR,—I was delighted to read Professor Douglas Roy's "Who does the surgery?" (25 November, p 1474). The approach to the training, role, and career structure of the "specialist" district physician outlined is admirable, and could be adopted in my own country with great benefit to our various peoples.

However, I believe the programme errs in excluding anaesthesia (suggested as optional) as an essential component. Even if anaesthesia is given by specially trained assistants, I believe the knowledge and expertise gained during three to six months' intensive training in anaesthesia could be of great benefit to the district physician, not only in supervising his "anaesthetist" but also in providing valuable education and experience applicable to other fields—for example, the use of regional or conduction anaesthesia, neonatal resuscitation, management of acute cardiopulmonary failure, etc.

Also, would he not consider the role of the specially trained surgical assistant in dealing with routine surgical procedures (for example, herniotomy, circumcision, setting of fractures), as employed with success in other African countries, such as Malawi?

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Clinical medical officers

SIR,—Those who have been concerned about the status, role, and training of those clinical medical officers who carry out so much of the work involved in preventive child care and developmental surveillance will welcome the letter from Drs Gwynne Lewis and others (13 January, p 128) suggesting that they might in future work within general practice without necessarily being trained as principals. This was the solution that many of us hoped that the Court Report would recommend and it would have avoided the disagreements that have resulted in the report's being shelved rather than implemented.

Community physicians have the information and resources to identify those children needing immunisation or assessment, but this need not mean that the clinicians who do the field work should come under their jurisdiction: instead they should tender the work to general practices by contract, using only those practices which can deploy principals or assistants (who will often be married women