report by Raz *et al.*¹ on the clinical occurrence of stress incontinence in three women after medication with diphenylhydantoin for grand mal epilepsy. Using in-vitro techniques of measurement of the urethral pressure profile by the Brown and Wickham method on the urethra of the female dog, they proceeded to show a fall in the urethral pressure after administration of intravenous diphenylhydantoin. They gave intravenous noradrenaline, which produced a rise in urethral pressure but which was subsequently cancelled when diphenylhydantoin was administered. The suggested mode of action of diphenylhydantoin was to prevent the effective depolarisation of muscle cells, hence blocking the α -adrenergic effect of noradrenaline.

I would like to point out one error in this article: the dose of propantheline was incorrectly stated as 15-200 mg three times a day, whereas it should have read 15-20 mg three times a day.

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¹ Raz, S, Zeigler, M, and Caine, M, *Investigative Urology*, 1973, 10, 293.

Epilepsy in coeliac disease

SIR,—Small children with coeliac disease (or otherwise ill-nourished) are prone to hypoglycaemia during periods of fever and anorexia and this is one trigger of febrile fits in infancy. Cerebral swelling at this time may cause temporal damage and later epilepsy. It would be interesting to know, perhaps from their mothers, how many of the epileptic patients of Dr R W G Chapman and his colleagues (22 July, p 250) had convulsions in their first two or three years of life.

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Length of hospital stay

SIR,—The letters from Dr D Phillips-Miles and Mr H B J Chishick (17 June, p 1622) concerning the length of hospital stay of patients undergoing cataract surgery raise questions of unsatisfactory utilisation of beds. The mean length of hospital stay for such surgery in West Glamorgan in 1975 is variously stated to be six to 11 days depending on the surgeon (D Phillips-Miles) or 17 days for men and 25.4 days for women (H B J Chishick).

In Brookhaven Memorial Hospital during the first quarter of 1977 28 patients with cataracts were operated on, the average length of stay being 4.2 days. According to Professional Activities Study (PAS), which is a computerised hospital efficiency study used by hospitals throughout the United States, the average length of stay for cataract surgery from January to December 1975 was 5.8 days in the hospitals of the Eastern Region of the United States and 5.5 days in the whole of the United States.

All hospitals in the United States have utilisation committees, which supervise bed utilisation on a daily basis. Doctors whose patients stay longer than the expected norm must give a satisfactory explanation for the overstay. This is mandated by federal law.¹

Also Medicare (federal health insurance for the over-65 age group), Medicaid (federal-State health insurance for the indigent), and Blue Cross (non-profit voluntary hospital insurance)—which together cover 85% of hospital patients—will not pay hospitals for care unless it is considered medically indicated and cannot be rendered on an office or outpatient basis.

There have been repeated comments about poor utilisation in National Health Service hospitals.^{2,3} In some hospitals there is the will to be efficient, as in the outpatient herniotomy programme at the Royal Infirmary, Edinburgh. While much of medical care is determined by science and art, however, much more is determined by fashion.⁴ Examples of the influence of fashion are the therapeutic value of bed rest, which is questionable except in a very few circumstances; the use of aspirin, sleeping pills, and tranquillisers; and the difference in the length of hospital stay for the same condition in different communities.

The move to improved utilisation and efficiency must be encouraged to avoid the hotel aspect of early convalescence in hospital.

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¹ *Social Security Amendments of 1965*, Title XVII, section 1861 (k). Washington, DC, Government Printing Office, 1965.

² Jacoby, M G, *Lancet*, 1966, 1, 1366.

³ Pearson, R J, *et al*, *Lancet*, 1968, 2, 559.

⁴ Jacoby, M G, *New York State Journal of Medicine*, 1976, 76, 1504.

Treatment of ulcerative colitis

SIR,—We were interested by the letter of Dr A G Ironside and others (15 July, p 202) and agree that infectious diseases units have a contribution to make in the study of inflammatory bowel disease (IBD). We have studied patients with diarrhoea presenting to the infectious diseases unit at the City Hospital in Edinburgh¹ and have also encountered difficulties differentiating between IBD and infective colitis on the basis of the initial findings at sigmoidoscopy and rectal biopsy. Not only is this true of patients with specific intestinal infections but it also holds for those in whom no pathogen is isolated by routine methods—the very group of patients in whom IBD is most likely to be diagnosed mistakenly.

In our series 23 out of 36 patients with infective diarrhoea had negative stools and the diagnosis in these cases was made on clinical grounds. While some patients showed changes in the rectal mucosa similar to those reported in salmonellosis,² a few showed changes highly suggestive of IBD. Thus the potential for misdiagnosis of infective colitis for IBD is not confined to patients suffering from infection with the recognised "mimics"—salmonella, shigella, and *Entamoeba histolytica*.

Surveys of prevalence of hypernatraemia

	1 Jan–31 December 1973	1 Oct 1975–30 Sept 1976	1 Jan–31 December 1977
Total admissions	472	434	530
No with hypernatraemia	23*	11	5
Deaths with hypernatraemia . .	2†	1	1

*Three children had surgical disorders.

†One died with intussusception, peritonitis, and hypernatraemic dehydration.

This observation has important implications. While it remains impossible for service laboratories to search routinely for the less easily identified enteric pathogens, it is important that the diagnosis of IBD, with all its long-term social and therapeutic implications, is not made prematurely in patients with non-specific diarrhoea and suggestive changes in the rectal mucosa. At the same time we would endorse your correspondents' view that acute colitis of whatever cause merits the closest attention.

We do not, however, agree that bowel infections should be regarded as part of the spectrum of IBD. The essential difference between these conditions is that bowel infections are usually self-limiting, although there are well-documented reports of IBD developing after infective episodes. If infective colitis and IBD are regarded separately and their differences defined then further information may be obtained about the host factors that predispose to the development of IBD and the role of infective episodes in its causation.

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¹ Dickinson, R J, Gilmour, H M, and McClelland, D B L, *Gut*, in press.

² Day, D, Mandal, B K, and Morson, B M, *Histopathology*, 1978, 2, 117.

Infant feeding practices

SIR,—Drs Rosamond A K Jones and Elizabeth M Belsey (8 July, p 112) report a survey of infant feeding practices in a London borough. At the time of the survey (1975) unmodified milks were still widely used despite their high solute loads related to their sodium contents and the increased risks of excess solute load if such feeds are overconcentrated. The authors refer to observations made in our gastroenteritis unit,¹ which showed a decline in hypernatraemic dehydration in children with gastroenteritis but persistence of the problem to some degree in infants fed on low solute milks. A more recent survey (see table) has shown a further substantial fall in the prevalence of hypernatraemia; furthermore, of those who had hypernatraemia only one child had a plasma sodium concentration above 160 mmol(mEq)/l—namely, 194 mmol/l—and this child subsequently died.

It thus appears to be clear to us that there has been a dramatic and quite remarkable reduction in the incidence of hypernatraemia in infants with gastroenteritis admitted to our unit. We believe that this must be related to the abandonment of unmodified milks and the