from vesicoureteric reflux over a period of 15 years in this area cystourethroscopy, with measurement of the submucosal ureter and calibration of the urethra, has been a routine part of the investigation. The length of the intramural ureter is of considerably less value than that of the submucosal ureter. I consider these endoscopic procedures to be invaluable in helping to decide if reflux is likely to disappear spontaneously or not and therefore a great help in determining a rational programme of treatment. If the length of the submucosal ureter is over 0.5 cm and the bladder and urethra otherwise normal the reflux will almost certainly disappear spontaneously. This, as Dr Edwards has pointed out, may well take longer than two years, but with the confidence of a normal cystourethroscopic examination and an adequate submucosal ureter no arbitrary time limit need be set for "failed medical treatment." About 60% of children come into this class.

Cystourethroscopy is also invaluable in revealing defects which may escape radiology, and I believe that operation should be recommended early when it is clear that no amount of time will result in a spontaneous cure—for example, poorly developed trigone with widely separated gaping ureters, absence of any submucosal ureter, ureter opening into a diverticulum, varieties of duplex, etc. Rare cases of distal obstruction may on occasions escape detection by radiology.

I have found that on cystourethroscopic examination about 25% of children are recommended as candidates for operation. In about 15%, in whom the submucosal ureter is about 0.5 cm or less, the age of the child and severity of reflux, as well as social, geographical, and temperamental factors, play a large part in the planned treatment of the child. In the child with established renal scarring I consider cystourethroscopy to be mandatory if conservative treatment is planned, as only by this examination can the early resolution of reflux be forecast. This examination will spare a few children with established scarring from operation, but I consider that it is unjustifiable to await further evidence of renal scarring before recommending operative treatment as factors other than infections alone are involved in the production of renal damage, especially where there is intrarenal reflux.

In conclusion, I suggest that cystourethroscopy should be a routine in the assessment of children with vesicoureteric reflux as it allows a fairly accurate prediction of the disappearance or otherwise of the reflux to be made. This will allow treatment to be planned with confidence, reduces exposure to radiation, and should prevent further renal damage in those who have already sustained scarring.

G B MCKELVIE

Department of Urology,
Falkirk and Stirling Infirmarys,
Stirlingshire

Infantile acne

SIR,—I think that Dr S J Carne (6 August, p 389) has missed the point of my letter. He is quite right in suggesting that milia appears very soon after birth, in contrast to the lesions in the children I observed, which were not apparent before three weeks of age in any case. Indeed, the appearance was not characteristically that associated with milia, which takes its name from its resemblance to millet seed. There was marked improvement when the

children were "treated" with an oestrogen/progestogen combination via breast milk. I felt, therefore, that it was reasonable to assume that the skin condition may have, at least in part, a hormonal basis, and that the oestrogen derivative of the pill may well have been counteracting a predominantly androgen effect. There is, of course, thought to be a similar explanation for the improvement of acne vulgaris in adolescent girls given the contraceptive pill.

D ROWLEY-JONES

Baldock, Herts

Renal lead excretion

SIR,—In recent years there has been increasing concern that present levels of environmental lead pollution, although not causing frank lead poisoning, may nevertheless be harmful to health. There is evidence that this is particularly likely where lead contaminates drinking water supplies.¹⁻⁴ Our previous studies have demonstrated associations between lead and both hypertension³ and renal insufficiency.⁴

In those studies, however, it was conceded that the disease states themselves might be partly responsible for the elevations of blood lead concentration by depressing renal lead excretion—in other words, that they might be the cause rather than the result of elevated blood lead concentrations. If minor degrees of renal impairment encountered in such epidemiological studies were indeed the cause of elevated blood lead levels one would expect to find some evidence of depressed lead excretion in subjects with severe renal dysfunction.

Accordingly we have looked at 12 patients, nine male and three female, aged 18-72 years, with differing levels of renal function as assessed by creatinine clearance. Four patients had normal renal function; four moderate renal impairment; and four had severe renal failure (table). In each case blood lead concentration was measured and urinary lead output determined over three consecutive 24-h periods. These measurements were made by flameless atomic absorption spectrophotometry and by polarography. Only about one-tenth of total blood lead is carried in the plasma and the technical difficulties encountered in the accurate measurement of such small concentrations makes formal renal lead clearance determination unreliable. This therefore was not attempted. Instead, the relationship of blood lead concentration to

urinary lead output is expressed as a simple arithmetic function in the final column of the table.

In all subjects urinary lead output was of the same order irrespective of renal function and, with one exception, blood lead concentrations fell within the normal range. The ratio of blood lead concentration to urinary lead output varied greatly but was in no way related to severity of renal disease. Clearly, this is an unsophisticated parameter, but because of the technical difficulties mentioned it is as accurate a reflection of renal lead handling as any other.

These findings indicate that it is unlikely that renal impairment is a significant cause of elevated blood lead concentration and that it is more probable that excessive lead in water is indeed one factor in the development of hypertension and renal disease in some subjects.

BRIAN C CAMPBELL

HENRY L ELLIOTT

Department of Materia
Medica,
Stobhill General Hospital,
Glasgow

¹ Beattie, A D, *et al*, *British Medical Journal*, 1972, 2, 491.

² Beattie, A D, *et al*, *Lancet*, 1975, 1, 589.

³ Beavers, D G, *et al*, *Lancet*, 1976, 2, 1.

⁴ Campbell, B C, *et al*, *British Medical Journal*, 1977, 1, 482.

Danger of instant adhesives

SIR,—There has been considerable concern about the dangers from cyanocrylate glues, the glues that set within seconds by exclusion of air. It is possible to dissolve the glue both before it has set and after it has set using materials which are somewhat irritant but not unacceptably so under medical and nursing supervision.

If the glue has not set contaminated fingers should be kept well apart and immersed in water. This will then set the glue. The dry glue will come off the hands as the skin naturally replaces itself in the course of a day or so. Alternatively, the glue can be dissolved in xylene or toluene solvents, which are fairly common in laboratory and industrial settings and which are not unduly irritant to the skin. They would not be suitable for use in the eyes or in the mouth, of course.

Should body parts be stuck together and it be unacceptable to wait for the glue to fall off naturally, it can be dissolved by swabbing with a solution of nitromethane. This material is not particularly irritant to the skin, has a

Effect of renal dysfunction on blood lead concentration and urinary lead excretion

Case No	Age (years)	Sex	Creatinine clearance ml/min	Blood lead $\mu\text{mol/l}$	Urinary lead $\mu\text{mol/24 h}$	Ratio blood:urine
Normal renal function						
1	28	M	131	0.7	0.05	14
2	44	M	111	0.7	0.02	35
3	18	M	146	0.7	0.03	23
4	19	M	147	0.6	0.02	30
Moderate renal impairment						
5	67	F	22	0.9	0.09	10
6	72	F	24	0.7	0.14	5
7	35	M	30	1.3	0.18	7
8	61	F	16	2.2	0.18	12
Severe renal failure						
9	37	M	3	0.8	0.02	40
10	56	M	2	0.8	0.02	40
11	43	M	9	0.5	0.07	7
12	48	M	4	1.2	0.10	12

Conversion: SI to traditional units—Lead: 1 $\mu\text{mol/l} \approx 20.7 \mu\text{g/100 ml}$; 1 $\mu\text{mol/24 h} \approx 207 \mu\text{g/24 h}$

reputation for being inflammable, and is commonly available dissolved in alcohol as model aircraft engine fuel. This material would not, of course, be suitable for use in the eyes; here there seems to be no alternative but to wait for the glue, which seems itself not to be irritant, to fall out. One would hesitate to use it in the mouth, but it might be reasonable if the situation justified the risks. Methylene chloride, commonly found in non-alkaline paint thinners, is capable of dissolving the glue, but it is irritant to the skin and does take a very long time.

I personally have stuck my fingers together with one of the glues and on each occasion separated them without any trauma at all in less than five minutes using nitromethane.

I PICTON-ROBINSON
Senior Medical Officer,
British Leyland UK Ltd

Longbridge,
Birmingham

Catatonic stupor responsive to ECT

SIR,—In view of the informative report by Drs William R Breakey and A K Kala on typhoid catatonia responsive to electric convulsion therapy (ECT) (6 August, p 357) it is of interest to note that in 1964 I reported¹ a case of catatonic-type stupor subsequent to a severe head injury which, after very careful assessment and supervision, was treated with ECT more than seven months after the original injury. At the time of treatment the stupor was in fact deepening. In common with the patients reported by Drs Breakey and Kala, the previous personality of my patient was well-integrated, family history was negative, and there was no positive psychiatric history prior to the accident. Contrary to the statement of Drs Breakey and Kala that catatonia in acute brain disorders subsides with treatment of the underlying disease, the stupor in the patient on whom I reported was, as stated, deepening. After ECT the patient made a good recovery which was maintained during a period of follow-up of 5½ years since discharge from hospital, and his progress was substantiated by formal psychometric testing.

MAURICE SILVERMAN

Department of Psychological
Medicine,
Queen's Park Hospital,
Blackburn, Lancs

¹ Silverman, M, *British Journal of Psychiatry*, 1964, 110, 648.

Carbon dioxide-dependent staphylococcus

SIR,—Dr M Rahman (30 July, p 319) reports the finding of a carbon dioxide-dependent *Staphylococcus aureus* in pus from an abscess.

We recently isolated a similar organism from an axillary abscess following insect bites. It differed from Dr Rahman's strain in being able to grow on blood agar in air, but its growth was so delicate that it was first thought to be a non-haemolytic streptococcus. As with Dr Rahman's strain, enhancement of its growth by CO₂ was first noted by its good growth under anaerobic conditions in an atmosphere of 90% hydrogen and 10% CO₂ and was confirmed by even better growth in air containing 10% CO₂. The organism was coagulase-positive, fermented mannitol, and was sensitive to methicillin, fusidin, genta-

micin, and lincomycin and resistant to penicillin and tetracycline.

The patient's condition responded promptly to treatment with flucloxacillin.

A BECK
G HOUNSOME

Microbiology Department,
Charing Cross Hospital
Medical School,
London W6

Survival of specialist societies

SIR,—Dr R A Goodbody (23 July, p 264) raises an important matter in these days of advancing knowledge in the different scientific medical disciplines and the expense of keeping up to date.

It has always seemed an anachronism that the part-time consultant can get tax relief for study leave if it is approved by the employing authority, whereas the full-time consultant is given no relief at all. Furthermore, the employing authorities, who would benefit exclusively from the knowledge acquired by the full-time consultant, will not reimburse expenses.

E W B VARLEY

Addenbrooke's Hospital,
Cambridge

How many medical students?

SIR,—The crystal ball (NHS issue) provided for those of us who are trying both to manage the Health Service now and plan for its future is cloudy at the best of times. Viewed by one who has read your reports of the recent proceedings in Glasgow it becomes positively opaque. On the one hand your Annual Representative Meeting fears that there are going to be too many doctors and calls for a freeze. On the other the conference of local medical committees fears that there are going to be too few general practitioners. Each set of fears is embodied in a suitable resolution.

While there are undoubtedly problems of maldistribution, geographical and between specialties, the information I and my health authority colleagues receive is that we are in total short of the number of doctors we need to meet the demands the public is making—demands, indeed, that the medical profession, the NHS, and successive governments have encouraged the public to make.

It would be unfortunate if the mistakes of the Willink Committee were repeated. We can only hope that the BMA will be able to shape a coherent policy for the profession which will take account not only of the legitimate aspirations of doctors for a satisfactory career structure but also of the community's need for medical care, for which the community must be prepared to pay.

As to how policy is to be shaped on the basis of resolutions passed it is not my business to say, although perhaps I may usefully call attention to the admirable solution to a not dissimilar problem arrived at by the contributor to the *Eatonswill Gazette* who was required to prepare an article on Chinese metaphysics. Taking the *Encyclopaedia Britannica*, "he read for metaphysics under the letter M, and for China under the letter C, and combined his information."

JOHN BETTINSON
Chairman,
National Association of Health Authorities
in England and Wales

London W2

GMSC and the Court Report

SIR,—I deplore the tone of the letter from Dr P D Hooper and his colleagues (16 July, p 193) on the subject of the memorandum of the General Medical Services Committee on the Court Report. The doctors concerned are entitled to their opinion that our recommendations are superficial and that we have misunderstood the recommendations of the Court Committee. I must, however, take issue with them when they suggest that the GMSC "are divorced from the views of their members." I would point out that our recommendations on the Court Report were overwhelmingly endorsed (with one minor amendment) by the Annual Conference of Local Medical Committees in Glasgow, representing all general practitioners in the NHS.

In addition, a similar policy has been endorsed by the Medical Advisory Committee to the DHSS, the Central Committee for Hospital Medical Services, the Central Committee for Community Medicine, the Joint Consultants Committee, the Royal College of General Practitioners, and most of the nursing organisations. Also, the British Paediatric Association suggest that the title "general practitioner paediatrician" should not be used.

I leave it to your readers to decide who is out of step. Is it not possible that Dr Hooper and company have done the very thing which they have accused us of—namely, that they have not really understood the majority policy of the profession? This accepts the need for improvement in child care and better education of all the professionals concerned. At the same time the profession is opposed to the particular recommendations of the general practitioner paediatrician and the child health visitor, which it is thought would diversify the primary care team.

ARNOLD ELLIOTT
Chairman,
Court Report Working Group,
General Medical Services Committee

Barkingside,
Ilford, Essex

Industrial action

SIR,—In your issue of 13 August you print 10 letters on the subject of doctors and industrial action, nine of which are critical, which of course they have every right to be, of the very solid and nearly unanimous decisions taken not by a clique of the establishment but by duly appointed representatives of virtually every section of the profession.

If democratic responsibility is to mean anything—and by this I do not refer to one man, one vote—there are certain questions which one has a right to demand shall be answered by the congenial resigners, non-joiners, and free-loaders.

Just how many meetings of the Association, either locally or nationally, did you attend and vote at during the past year?

Just how does donating any extra salary (and incidentally saving your BMA subscription) to a cancer campaign or other no doubt worthwhile charity assist your Association to pay for the necessary material and staff to maintain your case?

If you are so sure of your rectitude just what would you do? Nothing?

And while the letters pour in, the doctrinaires who are determined to humble doctors and medicine continue their own sweet way, absolutely certain who are our worst enemies. Unlike the Duke of Wellington's men, of this