Also it should be borne in mind that, particularly in the larger series, a decrease in infection rate will be due in part to the fact that the problem is being investigated (the "Hawthorn effect"), resulting inevitably in greater awareness and therefore greater care among all grades of staff involved.

In our work with shunting devices for hydrocephalus we have found that "late" infections are invariably missed "early" infections.⁶ This was confirmed only because the patients were seen frequently after operation and serum antibody titres and C-reactive protein levels were estimated routinely, even when they were clinically fit.

Obviously true late infections may occur after total hip replacement and there is good evidence to support the view that such a diagnosis may be quite valid.⁷⁻¹¹ However, we would suggest that frequent follow-up coupled with routine serological testing would clarify whether these are true late infections or missed early infections.

R BAYSTON
R B ZACHARY

University Departments of
Paediatrics and Paediatric
Surgery,
Children's Hospital,
Sheffield

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Malignancy in relatives of "non-responders" to Rh antigen

SIR,—It is well recognised now that about 20% on average, of Rh-negative male blood transfusion volunteers cannot be immunised to the Rh antigen despite repeated or varying doses of Rh-positive blood or both.¹⁻³ These "non-responders" are possibly immunologically incompetent to some extent despite their good health. In order to obtain further information on this point, we interviewed 25 such "non-responder" and 21 "responder"

donors concerning their detailed medical and family histories, with particular reference to malignancies and infections. We have not investigated the "responder" status of the relatives.

The accompanying table shows that in 267 relatives in the "non-responder" group there were 17 cases of malignancy (13 confirmed or both), while eight cases of malignancy (six confirmed) were found in the 297 relatives in the "responder" group. No evidence of an increase in infections was found.

For the findings to have any significance we would need at least 100 men in each group investigated similarly and hence a combined survey involving other transfusion centres is required. We would be willing to supply specific details of our questionnaire and data to those interested.

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IAIN A COOK
SALLY SHEPHERD

North of Scotland Blood
Transfusion Service,
Raigmore Hospital,
Inverness

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Urinary incontinence in children

SIR,—Dr Roy Meadow has provided a great deal of useful information in his paper (27 August, p 567) and the *BMJ* is to be congratulated on continuing to highlight the problem of urinary incontinence, now apparently in the main stream after many years in the backwaters of medical interest. Whereas your leading article on stress incontinence (2 July, p 3) has been criticised by some correspondents on the grounds that it advocates over-investigation, I think Dr Meadow rather underemphasises investigation. Reading between the lines, it seems likely that he investigates the incontinent child's urinary tract by excretion urography, micturition cystography, cystometry, and endoscopy when simple measures fail. However, the lack of emphasis on investigation leading to accurate diagnosis of the bladder and urethral problem may mislead readers into thinking that there is no real point in investigating the incontinent child. This impression may be reinforced by

the paucity of treatment offered—namely, bladder expression, incontinence pads and appliances, catheters, and diversion. True, "urethral dilatation or other minor urological surgery" is mentioned in passing.

The overactive bladder causing incontinence may be treated successfully with anticholinergic drugs. Hydrodistension has also been used. Of course, bladder irritability may be due to infection, and this must first be excluded. Dr Meadow refers to the problem of dribbling around the catheter. This may result from bladder hyperactivity and may respond to anticholinergic drugs. Catheters blocked by debris or kinking may also cause bypassing. Intermittent drainage of urine is usually to be preferred, particularly in the older patient, since freedom from a bag makes the problem less obvious and also reduces the risk of ulceration of the bladder by the tip of the catheter, another cause of bladder irritability leading to bypassing. The smallest size catheter and the smallest volume in the balloon consistent with adequate drainage and security should be used. Large catheters and balloons are more likely to provoke bypassing. Intermittent catheterisation once or even twice daily in the female together with expression and training probably offers the easiest non-operative procedure when incontinence results from an atonic bladder. The mother can be trained to do this initially, and later the girl herself may be capable and willing to perform this simple procedure.

Dr Meadow mentions bladder training. This is important, and bowel training should also be considered, especially in the "neuropathic" group. The defecation reflex is often poor and a lower bowel loaded with faeces may interfere with bladder emptying, presumably by pressure on the bladder neck. Physiotherapy and electrical stimulation should also be considered, including the use of patient-operated miniaturised stimulators.

A great deal of work has been done in recent years to improve the diagnosis and subsequent treatment of the various types of urinary incontinence. The extent of this continuing work can best be seen in the Proceedings of the International Continence Society, which are published regularly in *Urologia Internationalis*.

ERIC S GLEN

Urodynamic Service,
Department of Urology,
Southern General Hospital,
Glasgow

Effect of wholemeal and white bread on iron absorption

SIR,—The contribution by Drs R J Dobbs and I MacLean Baird (25 June, p 1641) has provided short-term evidence which, combined with that reported by other workers, indicates that consumption of bran or brown bread, because of the phytic acid contribution, can reduce the absorption of iron, calcium, and zinc. To carry conviction, however, it is necessary to demonstrate that, in a Western dietary context, habitually high consumers of phytic acid are unequivocally stigmatised in mineral status compared with low consumers.

The evidence incriminating phytic acid, based on relatively brief studies on humans and animals, is often at variance with epidemiological evidence, the principal exception being the experience in Iran.¹ In South Africa Blacks in rural areas are accustomed to a relatively high intake of phytic acid. Yet our

Malignancies in relatives of non-responder and responder donors

Relatives	Non-responder donors (n = 25)				Responder donors (n = 21)			
	Total No	Malignancies		Deceased	Total No	Malignancies		Deceased
		C*	Uc*			C*	Uc*	
Children { M	30				31			
F	32				18			
Brothers	34	1†			40			
Sisters	27				32	1		
Fathers	24	4	1		21			
Mothers	25	4	3		21			
Paternal aunts	21	1			28			
Paternal uncles	29	2			28		1	
Maternal aunts	23				44	1	1	
Maternal uncles	22	1			31	4		
Total	267	13	4	58	294	6	2	94
		(17)				(8)		

*C = confirmed, Uc = unconfirmed.
†Hodgkin's disease.