AUTHOR'S REPLY.—Spinal cord compression in patients with small cell lung cancer is associated with very poor prognosis—30 weeks' median survival for the six patients in our series who presented with it at diagnosis; four weeks when presenting as relapse and only given steroids; and six weeks if given steroids and radiotherapy.¹

Dr Husband is quite correct that you cannot offer prophylactic radiotherapy to those who develop spinal cord compression as the presentation of their disease. If, however, you could prevent cord compression as a relapse you would improve the potential quality of life of the patient.

Of the 18 patients who relapsed with spinal cord symptoms, five (28%) had a positive bone scan at the appropriate site and two others had abnormal relevant vertebral bodies on plain radiology; eight (44.5%) had back pain. On the other hand, 11 had normal bone scans when spinal cord compression developed, suggesting predominantly intrathecal disease. Radiotherapy applied to virtually any site will give local protection from small cell lung cancer. We suggest that in nearly half the patients who develop spinal cord compression it might have been prevented if a policy had existed to prophylactically irradiate painful hot areas on the bone scan in the thoracolumbar spine. Others have shown this to be effective. This approach will not stop all spinal cord compression—particularly if the disease is mainly intrathecal. If this policy is adopted some patients will be treated unnecessarily but it is unlikely to be harmful within the context of the disease.

We readily accept that laminectomy is often inappropriate as the disease is usually situated anteriorly in the vertebral body. Only three of our patients had surgery, including two of the six who presented with spinal cord compression. However, as several of these patients had widespread disease at the time of spinal relapse, sometimes affecting more than one vertebra, and as noted in our series a considerable number had no obvious bony involvement, the role of surgical decompression in such a rapidly progressive disease must remain small and highly selective.

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1 Goldman JM, Ash CM, Souhami RL, et al. Spinal cord compression in small cell lung cancer: a retrospective study of 610 patients. *Br J Cancer* 1989;59:591-3.

Product licence applications

SIR.—The paper by Professor Michael D Rawlins and Dr David B Jefferys¹ is similar to the spate of reports issued over many years by Wardell and Lasagna from the University of Rochester, New York, dealing with both American and overseas product licence applications. Of course it is of some interest to get a reading on the number of "innovative" or "semi-innovative" drug licence applications and what percentage were granted conditional or unconditional approval.

Like Wardell and Lasagna, Professor Rawlins and Dr Jefferys omit the all important analysis of what percentage of any of these compounds constituted real progress in the treatment of patients. Their conclusion that "the results suggest a broadening of the pharmaceutical industry's research and development programmes..." is a non-sequitur, unless we have substantial information based on controlled studies as to whether any or several of these newly licensed compounds produced a substantial improvement in treatment possibilities.

Surely the authors are aware that many "new" substances only fill in the place of other substances of similar value whose patent has expired or just add to the number of available and similar compounds, leading to a surfeit of available sub-

stances, and, more importantly, through intensive marketing to more and unnecessary overmedication of our patients.

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1 Rawlins DM, Jefferys DB. Study of United Kingdom product licence applications containing new active substances, 1987-9. *BMJ* 1991;302:223-5. (26 January.)

AUTHORS' REPLY.—Several schemes for classifying the innovative status of new drugs have been described, but we chose the Lunde-Dukes method¹ for two reasons. Firstly, it is entirely objective and does not demand a judgment of value in the first assignment of a drug to an individual class. This was particularly important in the context of the work described in our paper, which was largely based on confidential information and almost incapable of independent analysis or replication. Secondly, the classification has been used more widely than others and would, therefore, more readily facilitate comparisons.

Dr Frederick Wolfe is incorrect, however, in drawing too close a comparison between our study and the influential work of Wardell and Lasagna. Whereas these two authors have been mainly concerned with studying national and international approval rates and times in North America, in our analysis we have been concerned with the drug approval process itself.

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1 Lunde I, Dukes MNG. Les répercussions du contrôle administratif des médicaments: étude comparée de la situation en Norvège et aux Pays-Bas. *Industrie Santé* 1980;49:37-57.

Treating bed wetting

SIR.—Dr Dora Black¹ and Dr Sue Adams² re-emphasise the fact that intensive psychotherapy, drug treatment, behaviour therapy, electrical devices, and especially social and psychological misery are still endured by families with persistently bed wetting children. How sad that all these mistreatments and the misery continue almost 60 years after Denny-Brown and Robertson put forward the concept that persisting bed wetting may be hereditary and a developmental delay.³ Over the following six decades several publications in respectable journals supported the genetic basis of enuresis nocturna.^{4,7}

In 1983 the *Journal of the Royal Society of Medicine* published an article on enuresis omitting heredity⁸ and subsequently my letter describing a survey of 100 enuretic children in Israel.⁹ In the 81 families of probands who had siblings above the age of 4 years a positive family history in the first degree relatives (siblings or parents, or both) was found in 73%. When cousins and uncles were also included the incidence of family involvement rose to 83% (75 families). Various members of the same family stopped bed wetting at the same age.

How sad that establishing scientific facts will rarely change long held misconceptions. It seems that the concept persists that nocturnal bed wetting reflects a varying degree of psychopathology and should be treated. Whether treated with drugs, conditioning, or psychotherapy, bed wetting remains psychiatric territory. The psychiatric approach continues even when no clear behavioural or psychological pattern was established in enuretic children, and drug treatment usually has no effect. Enuresis continues to be the domain of psychiatry despite the evidence that it is a function of

maturation, showing similar interfamilial variations to other developmental milestones, especially development of language and menarche.

Doctor means teacher. Doctoring the bed wetting problem would mean teaching parents and children about the inborn nature of delayed bed wetting; teaching families that the tendency is inherited from one or both parents and that it disappears spontaneously with time. If we doctors treat our bed wetting patients in our teacher capacity then quality of life will increase more than with drugs and psychotherapy combined—and without any danger or side effects.

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- 1 Black D. Psychotropic drugs for problem children. *BMJ* 1991; 302:190-1. (26 January.)
- 2 Adams S. Prescribing of psychotropic drugs to children and adolescents. *BMJ* 1991;302:217. (26 January.)
- 3 Denny-Brown D, Robertson EG. On the physiology of micturition. *Brain* 1933;56:149-90.
- 4 Gesell AL, Ilg FL. *The infant and child in the culture of today*. New York: Harper, 1943:332.
- 5 Bakwin H. Enuresis in children. *J Pediatr* 1961;58:806-19.
- 6 Harbour RF, Borland EM, Boyd MM, Miller A. Enuresis as a disorder of development. *BMJ* 1963;i:787-90.
- 7 Klackenberg G. Nocturnal enuresis in a longitudinal perspective. *Acta Paediatr Scand* 1981;70:453-7.
- 8 Black J. Nocturnal enuresis. *J R Soc Med* 1983;76:632-3.
- 9 Elian M, Elian E, Kaushansky A. Nocturnal enuresis: a familial condition. *J R Soc Med* 1984;77:529-30.

Medical registrar training

SIR.—There seems to be a fundamental misunderstanding in the letter from Dr D Wynick and his colleagues relating to medical registrar training.¹

The Joint Planning Advisory Committee considers all potential NHS consultant posts, whether associated with substantive or with honorary NHS contract holders, when making its deliberations as to the likely numbers of career senior registrars and registrars required for the future. Thus, the 31 full time academic posts held by professors, readers, and senior lecturers that were identified by Dr Wynick and colleagues would be encompassed by the committee's formula, assuming that each of the 31 doctors concerned held an honorary NHS contract.

Apart from this misunderstanding, the details of this useful survey, which was carried out at the Hammersmith Hospital, show clearly the welcome flux that exists between academia and research and the NHS. It was the recognition of this fact that academic and research posts could not be considered in isolation from NHS posts as far as manpower planning is concerned that led to the so called tripartite agreement in 1985 and the subsequent establishment of the Joint Advisory Planning Committee.

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1 Wynick D, Rees AJ, Waxman J, Bloom SR, Dollery CT. Medical registrar training. *BMJ* 1991;302:595. (9 March.)

Teaching juniors practical procedures

SIR.—As Dr Alison Walker points out,¹ formal teaching of practical procedures at the undergraduate level is urgently required to prepare medical students for their preregistration posts.

In the United Kingdom most doctors are taught invasive procedures on acutely ill patients with varying degrees of supervision. Inevitably, this leads to prolonged discomfort for the patient and a high rate of complications as the doctor ascends "the learning curve."