responded well to this approach. Less than 25% needed to have a buzzer, which was offered only to children over 7 years of age. In some resistant cases the help of the child guidance team was sought. Many have needed some sort of social intervention.

The symptom of enuresis can be used as an indicator of stress in children. This can range from domestic disquiet to peer group discord or unsolved educational problems. Management of enuresis is time consuming. The greater part of it is ongoing personal counselling and support. A busy general practitioner should not be blamed for not being able to provide this service amidst his commitment to treat the acute illnesses of the rest of his generic clientele. Hospital treatment is expensive.

It appears to me that community health services providing clinical medical officers with specialist training or experience in paediatrics and based at health centres can play a singularly effective role in the management of enuresis.

I C SETHURAJAN

Community Health Services,
London W3

"The First Year of Life"

SIR,—I note that Dr H B Valman's book has appeared, to coincide with the last of his articles. It seems a great shame and a missed opportunity not to have incorporated some of the correspondence that the articles have produced. Many letters have contained constructive criticism and their inclusion would have increased the value of the book. Letters to the editor in any periodical mean so much more if read in association with the original article.

As you well know, it often takes years for corrections and new ideas to find their way into textbooks, but you had a splendid opportunity to combine an original manuscript with readers' observations.

JULIAN VERBOV

Royal Liverpool Children's Hospital,
Liverpool L7 7DG

*. *We showed this letter to Dr Valman, who replied as follows.—ED, *BMJ*.

SIR,—I would like to thank Dr Verbov and all who took the trouble to write to the *BMJ* about the series "The First Year of Life." Several points from these letters were, in fact, incorporated in the final versions of the articles as they appeared in book form—the very short delay between publication of the last article and the appearance of the book is a tribute to the printers' efficiency. Few authors of books have received the help of so many informed proof readers.

H B VALMAN

Northwick Park Hospital,
Harrow, Middx HA1 3UJ

Drugs and rheumatoid arthritis

SIR,—Dr H F West (26 July, p 310) raises an interesting point about the relative efficacies of cortisone and prednisolone in rheumatoid arthritis.

Though adrenocorticotrophic hormone (ACTH) treatment has its attractions for some patients (high compliance, easier to stop than prednisolone, fewer long-term side effects), we have seen a few patients on treatment with

ACTH whose rheumatoid arthritis was going badly despite a dose high enough to cause Cushingoid facies; substituting prednisolone at what we judged to be comparable doses led to improvement in the arthritis (with falls in erythrocyte sedimentation rate and serum C-reactive protein) and pronounced reduction in Cushingoid features.

Such comparisons between ACTH and prednisolone, using objective criteria, seem to need further study. Similarly, most rheumatologists believe that synthetic analogues (for example, triamcinolone, dexamethasone) have no advantage over prednisolone, being more effective weight for weight, but more likely to lead to side effects. There are, however, so far as we know, no definitive studies reported in the literature.

BRIAN MCCONKEY

Rheumatology Division,
Department of Medicine,
Dudley Road Hospital,
Birmingham B18 7QH

Two jubilees in psychotherapy

SIR,—By definition a jubilee (your leading article, 26 July, p 256) is a period of rejoicing to mark a praiseworthy event in the past. Perhaps it merits recall that in 1935, 15 years after its foundation, it was decided to appoint a neurologist on the team of consultants of the Tavistock Clinic. His duty was to examine every patient prior to being accepted for psychotherapy. This systematic practice continued until 1940.

Such close integration of psychiatry and neurology must still be regarded as a unique feature in the practice of psychological medicine. I can testify that it proved of great benefit not only to the patients but also to the two disciplines concerned.

SIMON BEHRMAN

London W1N 1DA

SIR,—In your leading article you wrote about the diamond jubilee of the Tavistock Clinic (26 July, p 256) without mentioning the founder and first medical director, Dr Hugh Crichton-Millar. In fact, you refer only to developments since the second world war.

Hugh Crichton-Millar pioneered outpatient psychiatric treatment, child guidance, multi-disciplinary teams, and training. Most of the developments you mention would have been impossible if he had not provided the institutional framework and leadership and won wide public support during the critical early years.

D S MACPHAIL

Broadmoor Hospital,
Crowthorne, Berks RG11 7EG

Salute to Macdonald Critchley

SIR,—Without detracting in any way from your wonderful tribute to Macdonald Critchley (9 August, p 406), I was disappointed and astonished that no mention was made of his association with King's College Hospital, London. When Adren Turner retired from King's in 1928 Kinnier Wilson became head of the neurological department and Macdonald Critchley was appointed junior neurologist, becoming physician for nervous diseases in 1935. After the death of Kinnier Wilson in 1937 he became head of the department of

neurology. He was appointed lecturer in therapeutics and applied pharmacology in 1930 and became president of the Listerian Society during the session 1934-5. These facts can be verified in *King's and Some King's Men* and an addendum to that book.^{1 2}

Macdonald Critchley had an off-beat approach to medicine which resulted in many interesting papers, one of which I remember was about the body image. Among other things, he maintained that one's body image enlarged to correspond with the boundaries of the car one was driving.

Although Macdonald Critchley may have lacked the histrionic flair displayed by Kinnier Wilson when the latter was demonstrating a clinical "case," he had a subtle and erudite wit which was greatly appreciated by those whom he taught. He was one of my student-day heroes but unlike some others, who proved to have feet of clay when I matured and became a teaching consultant myself, he has retained my admiration and respect ever since I first knew him.

ARCHIE GALLEY

Ewell, Surrey KT17 1LX

¹ Lyle HW. *King's and some King's men*. London: Oxford University Press, 1935.

² Lyle HW. *An addendum to "King's and some King's men."* London: Oxford University Press, 1950.

Consensus development programme: technology assessment at NIH

SIR,—I write to correct an error in the article "The consensus development programme: technology assessment at the National Institutes of Health" by Dr C U Lowe (28 June, p 1583).

In the section concerned with the role of National Institutes of Health and its relationship to the National Center for Health Care Technology, there is the statement that "while NIH focuses on the technical, scientific aspects of assessments, the centre is concerned with ethical, social, economic, and legal facets." This is incorrect in that under the law (PL 95-623) which established the centre it is charged with evaluating health care technologies from *all* perspectives, including technical and scientific. The centre is also responsible for co-ordinating the health care technology assessment activities of agencies in the Department of Health and Human Services, including the National Institutes of Health.

It was my privilege to head the consensus development programme during its first two years, and for a full discussion of that programme and its relationships I would refer you to a recent paper.¹

SEYMOUR PERRY

National Center for Health Care Technology,
Rockville, Maryland 20857,
USA

¹ Perry S, Kalberer JT. *N Engl J Med* 1980;303:169-72.

Pleural aspiration and biopsy

SIR,—Dr W T Berrill (9 August, p 459) concludes that intracavitary bleomycin is not necessarily any more effective than other cytotoxic agents. We hope to answer this question when our multicentre study is completed in the near future.

The suggestion that one should not use bleomycin because it is four times as expensive

as thiotepea is to miss one of the points of our communication (5 July, p 64), which is that bleomycin is an effective, safer agent to use as it does not cause myelosuppression and can therefore be given to those patients who have previously received aggressive cytotoxic chemotherapy. Less than 50% of the dose is absorbed and systemic effects are minimal. In addition, the inadvertent subcutaneous injection of bleomycin does not cause tissue necrosis and ulceration. It is for these reasons that we consider intracavitary bleomycin a safer agent for both inexperienced and experienced oncologists to administer. It is up to the individual to decide what price he pays for that safety.

M J OSTROWSKI

Department of Radiotherapy
and Oncology,
Norfolk and Norwich Hospital,
Norwich NR1 3SR

Arterial puncture

SIR,—I would like to comment on the article by Professor D C Flenley in "Procedures in Practice" dealing with arterial puncture (12 July, p 128). I would agree with him that puncture of the brachial artery is preferable to the radial since the procedure is not only rather less painful at the brachial artery but is less likely to give rise to arterial thrombosis. However, his diagrams show very clearly in two places that he prefers puncture in the antecubital fossa or, it would appear, just below.

My main objection to this site is that the artery, although easily palpable, is often restricted by the bicipital aponeurosis and any haematoma forming there may cause pressure on the median nerve. We had three such cases some four or five years ago¹ and since then have carried out arterial puncture and cannulation about 2½ cm above the elbow crease or higher. In this site the artery is not tightly enclosed and we have had no further cases of median nerve damage. A subsidiary point which does not come out of the article is that the brachial artery bifurcates at the region of the elbow.

PETER SLEIGHT

Cardiac Department,
John Radcliffe Hospital,
Oxford OX3 9DU

¹ Littler WA. *Postgrad Med J* 1976;52, suppl 7:110-1.

SIR,—I read with interest the article by Professor D C Flenley on arterial puncture in the "Procedures in Practice" series (12 July, p 128). He describes the traditional technique of obtaining arterial blood, which I was taught as a medical student. This method, however, has numerous drawbacks.

Why, for example, is it necessary to use a green (21 G) needle? Such a large instrument is not only more painful but also causes more trauma to the artery than smaller needles. Perfectly adequate samples (even greater than the 10 ml suggested) may be obtained with orange (25 G) needles. A needle attached to a syringe may be difficult to manoeuvre while palpating the artery whereas that in the form of a "butterfly" may be gently inserted into the skin and manoeuvred over the vessel whence the transmitted pulsation of the vessel is easily seen moving the wings of the butterfly. The artery is then transfixed between index and middle finger while the other hand guides the needle into the vessel. The whole system—

that is, butterfly and plastic syringe—should have its dead space filled with heparin and on puncture of the vessel arterial blood is seen pulsating in the clear plastic tubing of the butterfly connector, thus obviating the need for a glass syringe. Gentle suction on the syringe then fills it with blood.

The use of 25 G needles enables the much more convenient radial artery to be punctured at the wrist. At this site palpation and transfixion of the artery is easier over the underlying bone. Indeed I have used this site on several occasions to obtain blood for reasons other than blood gas analysis in those such as the grossly obese in whom venepuncture is difficult if not impossible. The resulting haematoma is minimal provided constant pressure for five minutes is applied to the puncture site.

Professor Flenley claims that arterial puncture is a painful procedure requiring injection of local anaesthetic and that the "unbeliever should attempt it on himself. In the course of experiments my own radial artery has been punctured on several occasions. Each procedure was less painful than venepuncture and left a dull ache lasting a day over the site of the puncture.

ALYN MORICE

Accident and Emergency
Department,
Guy's Hospital,
London SE1 9RT

*.*We sent this letter to Professor Flenley, who replies as follows.—ED, *BMJ*.

SIR,—I recommend arterial puncture using a 21 G (green) needle in the brachial artery on the basis of extensive experience over the last 20 years. I have occasionally used a 25 G (orange) needle attached to a syringe, but have not found it easy to detect the pulsation of blood into the syringe (which is essential to identify that an artery, and not a vein, has been punctured) when using this smaller needle. I have no experience of a 21 G needle on a "butterfly," but suspect that the smaller diameter of needle will still have this disadvantage.

The reasons for preferring the brachial artery are as expressed in my article—namely, the patient is familiar with blood sampling at this site; the artery is of a reasonable size and is easily palpable; and, most importantly, the larger volume of the cubital fossa can accumulate any haematoma without excessive pain. I can only repeat that my own experience of several radial punctures on myself has been more painful than my many brachial punctures. I note that even Dr Morice had a dull ache lasting for a day after radial puncture, which in my experience is very unusual following venepuncture. I fail to see any objection to the use of local anaesthetic if this, as Dr Morice appears to agree, can diminish pain.

D C FLENLEY

Department of Respiratory
Medicine,
City Hospital,
Edinburgh EH10 5SB

Proctoscopy and sigmoidoscopy

SIR,—I was interested in the excellent article in your "Procedures and Practice" series by Mr D J Ellis and Mr P G Bevan (9 August, p 435).

I have found that one can do a most satis-

factory sigmoidoscopy under intravenous diazepam in the ward without needing to take the patient to theatre or give any more potent anaesthetic, and would commend the procedure for various reasons. It is carried out in the left lateral position with the patient lying across the bed with the buttocks right to the edge.

Preparation is everything and patients should receive an enema on the preceding night followed by nothing by mouth after midnight (it is essential that well-intending night staff be prevented from giving a cup of tea to the sleepy patient). This means that a Beogex (sodium bicarbonate and anhydrous sodium acid phosphate) suppository at 7 am, the patient then emptying the bowel at 8 am and 9 am, can be followed by perfect visualisation at 10 am. The advantage is that the rectum is dry and normal and any inflammation is pathological and not induced by the cleansing agent. In my experience it is not satisfactory to do a sigmoidoscopy without bowel preparation, for although the rectum may be clear there are practically always faeces obstructing the view in the sigmoid.

With this method it is quite possible to complete the whole operation, including a biopsy if necessary, in about five minutes; and the diazepam will produce amnesia in the patient afterwards. One might view it as a medical rather than a surgical sigmoidoscopy.

R V STONE

Park Hospital,
Manchester M31 3SL

SIR,—We would like to take issue with Mr D J Ellis and Mr P G Bevan (9 August, p 435) where they advise a general anaesthetic for full visualisation of the lower sigmoid colon and rectum during sigmoidoscopy.

The rectosigmoid junction is negotiable in most patients, without anaesthetic, if an "adolescent" (250 × 16 mm) sigmoidoscope is used. Usually only the anxious patients and those with rigidity of the sigmoid colon from diverticular disease pose any difficulty. The knee-elbow position facilitates negotiation of the rectosigmoid junction in these groups.

General anaesthetic does not facilitate the negotiation of the rectosigmoid junction and it carries a significantly greater risk of perforation of the colon from overinflation and injudicious advancement of the sigmoidoscope. It is also expensive in time and bed occupancy.

In those patients who do require a sigmoidoscopy under general anaesthetic we would still advise the use of the smaller sigmoidoscope, the larger one (300 × 19 mm) being reserved for difficult biopsy and operative procedures.

ROBERT TALBOT
RICHARD POCKOCK

St James's Hospital,
London SW12 8HW

Is it really a cerebrovascular accident?

SIR,—I was interested in Dr R L Bishton's letter (5 July, p 63). Professor Keith Simpson has this to say¹: "Avoid ambiguities like 'birth injuries,' 'cerebrovascular accident,' or 'termination of pregnancy,' qualification of which must be given to make it clear that they were natural and not accidental or criminal occurrences." Later in the same paragraph he continues, "Indeed, vagueness of any kind is