Diagnosis	No (%) in group	No (%) with increased abdominal pain after Picolax	No (%) reporting severe nuisance after Picolax	Mean (SD) increase in No of stools/24 h
Inflammatory bowel disease	55 (21)	7 (13)	9 (16)	5.2 (3.6)
Irritable bowel syndrome	114 (43)	29 (25)	29 (25)	8.6 (3.5)
Diverticular disease	35 (13)	3 (9)	7 (20)	9.3 (3.7)
Iron deficiency with negative results of investigations	31 (11)	7 (23)	0	7.3 (4.5)
Other*	32 (12)	8 (25)	3 (9)	7.2 (3.7)

*Includes patients with colonic carcinomas, polyps, haemorrhoids, and mesenteric ischaemia.

they did not experience severe adverse effects any more commonly than patients with other colonic disorders.

Many clinicians have heard anecdotal reports of severe adverse effects in inflammatory bowel disease, but the only published report of colonic perforation associated with use of Picolax occurred in a patient with a diverticulum proximal to an obstructing car-

cinoma.⁵ Interpreting anecdotal reports is difficult because of variation in the natural course of the disease among patients and because of changes in treatment about the time of investigation. If there is a tendency to severe adverse effects in inflammatory bowel disease it seems to affect few patients. We suggest that because of the practical benefit that would result from accurate knowledge of the prevalence of any such tendency a larger, cooperative study is merited.

- 1 De Lacey G, Benson M, Wilkins R, *et al*. Routine colonic lavage is unnecessary for double contrast barium enema in outpatients. *Br Med J* 1982;286:1021-2.
- 2 Lee JR, Ferrando JR. Variables in the preparation of the large intestine for double contrast barium enema examination. *Gut* 1984;25:69-72.
- 3 Fork F-T, Ekberg O, Nilsson G, *et al*. Colon cleansing regimes—a clinical study in 1200 patients. *Gastrointest Radiol* 1982;7:383-9.
- 4 Williams CB. Ulcerative colitis: diagnosis and the place of endoscopy. In: Allan RN, Keighley MRB, Alexander-Williams J, *et al*, eds. *Inflammatory bowel diseases*. Edinburgh: Churchill Livingstone, 1983:211.
- 5 Phipps RF, Fraser S. Faecal peritonitis induced by Picolax. *Br Med J* 1987;295:1027.

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Children of mothers with bulimia nervosa

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There is good evidence for a relation between certain psychiatric disorders in mothers and disturbance in their children.¹ Bulimia nervosa is an important source of morbidity in women of childbearing age.² It is characterised by recurrent episodes of gross overeating accompanied by extreme dieting, self induced vomiting, or abuse of laxatives. Patients also have overvalued ideas about shape and weight.³ Given these features and that most patients have appreciable symptoms of depression and anxiety, it might be predicted that the feeding and general development of the children of mothers with the disorder would be adversely affected. No studies of such children have been done other than one that suggested that some women with bulimia nervosa attempt to slim down their babies.⁴

Patients, methods, and results

We studied the records of 75 consecutive women with severe bulimia nervosa; 17 of them had children. Those whose children were aged 6 years or under were invited to participate in a study of childrearing. Six women were eligible, but one declined to take part. The remaining five had children whose ages ranged from 15 months to 6 years. One had a second child of 8 years, who was also included. The mothers were interviewed, with a standard protocol, about their childrearing and feeding practices and about their attitudes towards the shape and weight of their children.

In each case the mother's disturbed eating habits and attitudes seemed to have interfered with her parenting (table). Three mothers ignored their children for substantial periods while overeating and vomiting. Two mothers described being constantly irritable when overeating and vomiting and found it difficult to cope with their children's demands. Both resorted to smacking their young children repeatedly at these times. Two mothers had problems feeding their children because they restricted the amount of food in the house in an attempt to control their own food intake.

All five mothers had had difficulties breast feeding—for example, three had thought that it was distasteful and adversely affected their appearance, and as a result two had given up within five weeks. Another had had to stop because she was unable to produce sufficient milk, probably because she was following a diet of 3.2 MJ daily.

Three of the six children had major feeding problems. One had non-organic failure to thrive and despite repeated medical intervention remained below the third centile for weight; his sibling was severely overweight. A third child was resistant and difficult to feed.

Three mothers had unwarranted concerns about the shape and weight of their children and were anxious to keep their weight down—for example, one was preoccupied with the "large size" of her baby's buttocks and stomach and could not be reassured of their normality.

Comment

In each of these cases the mother's eating disorder seemed to have affected the way that she cared for her child. In some her disturbed eating had a direct impact—for example, during episodes of overeating

Details of five mothers with bulimia nervosa and their children

Case No	Age at presentation (years)	Duration of eating disorder (years)	History of anorexia nervosa	Age (years) and sex of child at assessment	Problem
1	31	14	Yes	3, M	Child ignored during bulimic episodes
2	28	10	No	1, F	Major feeding problems; lack of food in house complicated feeding; mother unduly concerned about child's shape and weight
3	27	8	No	3, M	Child ignored or punished during bulimic episodes; lack of food in house complicated feeding; mother unduly concerned about child's weight
4	22	4	No	1, F	Undue concern about child's shape and weight
5	28	14	No	6, M 8, F	Severely underweight with history of non-organic failure to thrive; school phobia; child ignored or punished during bulimic episodes Severe obesity

and vomiting some mothers were preoccupied and irritable and had to absent themselves. In addition, some resisted overeating by keeping limited amounts of food at home, and this complicated their child's feeding. The mothers' overconcern with shape and weight seemed also to have had an effect. It militated against breast feeding and was associated with undue concern about the children's shape and weight, which in turn affected how they were fed. Furthermore, the mothers' general psychiatric and personality disturbance may have influenced the children's development.¹

This small case series suggests that further research is needed on the children of mothers with bulimia nervosa. If our findings are confirmed doctors and

other health workers should be especially mindful of the feeding and development of such children.

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- 1 Rutter M. Parental mental disorder as a psychiatric risk factor. In: Hales RE, Frances AJ, eds. *American Psychiatric Association annual review*. Vol 6. Washington: American Psychiatric Press, 1987:647-63.
- 2 King MB. Eating disorders in general practice. *Br Med J* 1986;293:1412-4.
- 3 Fairburn CG, Cooper PJ. The clinical features of bulimia nervosa. *Br J Psychiatry* 1984;144:238-46.
- 4 Lacey JH, Smith G. Bulimia nervosa: the impact of pregnancy on mother and baby. *Br J Psychiatry* 1987;150:777-81.

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Why are operations cancelled?

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A large proportion of otolaryngological operations are non-urgent. Many patients who are called for operation from waiting lists are not operated on. This results in inefficient use of beds and wastes operating time. Putting patients who will not receive an operation on waiting lists lengthens the waiting time for patients who will be operated on. We looked at the reasons why patients on our waiting list failed to have an operation.

Patients, methods, and results

In keeping with the recommendation of the Körner report¹ data on non-attendance of patients for operation are recorded monthly and reasons for non-attendance are sought by letter. We surveyed all patients who were called for operation from our waiting list from October 1987 to September 1988 but were not operated on.

During the study period 3654 patients were sent for and 2652 operations were performed. The table shows the 20 reasons for non-attendance in order of frequency of occurrence.

Comment

The rate of non-attendance of patients at an otolaryngology outpatient clinic has been reported² but

Reasons why patients called for operation from otolaryngology department's waiting list failed to have operations during study

Reason	No of patients
Upper respiratory tract infection	219
Operation not needed	104
Appointment inconvenient	90
Operation not wanted	87
Patient did not attend*	82
Patient had moved away	71
Operation cancelled by hospital (no data)	49
Problems with job	45
Shortage of beds	44
Duplicate admission card (secretarial error)	30
Other illness or operation	30
Operation done privately	27
Patients taking contraceptive pill	22
Shortage of anaesthetists	22
Shortage of nurses	22
Family illness	20
Poor medical work up	14
Patient hypertensive on admission	10
Ear infection	7
Postal difficulties	7
Total	1002

*Reason unknown despite two reminders.

the rate of non-attendance for operation has not. This is probably due to lack of information before the recommendations of the Körner report were implemented.¹ Our study showed that among patients called for operation from the waiting list the rate of non-attendance by patients was 14.6% and the rate of cancellation by the hospital was 12.8%.

We identified 20 reasons why patients did not have an operation. Upper respiratory tract infection, the most common reason, is independent of seasonal variation and beyond control. Most of the patients whose operation was found to be unnecessary on admission or who decided that they did not want an operation had been listed not by consultants but by junior doctors in busy clinics; probably the numbers could have been reduced by more active involvement of the consultants. This suggests that more consultants are needed in the health service and may indicate that a move to a consultant based service would be more efficient in the long term.

For 90 patients the date of admission was inconvenient. Two of the three consultants in the unit had given two weeks' notice of admission. The other consultant had booked admissions at outpatient consultations, giving three months' notice and a choice of date. The rate of non-attendance was similar for the three firms, suggesting that this reason for cancelling operations is beyond our control. The operations cancelled because the patients had hypertension or were taking oral contraception or because the medical work up had been inadequate were clearly under medical control. Shortages of staff caused 44 cancellations and a shortage of beds due to emergency admissions a further 44 cancellations.

We agree with a report of a House of Commons working party, which suggested that waiting lists could be reduced by computerisation, by confirming that patients would attend for operation, and by screening to prevent unnecessary admissions.³ None of these can be achieved without capital expenditure.

We did not find that absenteeism among consultants was a problem, but the numbers of patients to be seen by junior medical staff in outpatient clinics may result in inefficient management.

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- 1 NHS/Department of Health and Social Security Steering Group on Health Services Information. *First report*. London: HMSO, 1982. (Körner report.)
- 2 Leese AM, Wilson JA, Murray JAM. A survey of the non-attendance rate at the ENT clinic of a district general hospital. *Clin Otolaryngol* 1986;11:37-40.
- 3 Committee of Public Accounts. *Fiftieth report: use of operating theatres in the National Health Service*. London: HMSO, 1988.

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