the psychiatric and urological confusion which has enshrouded the subject for so long. In brief, they have found, what anyone who has seen a large number of these children must know, that their only consistent deviation from normality is their inherited developmental delay in learning to be dry at night. Not one single enuretic, of course, will be helped by all this unless doctors take up the challenge and teach them to be dry by means of the buzzer. In the past, psychiatrists have obstructed its use on the grounds that, if the child is prevented from "weeping from his bladder," his emotional disturbance will break out in some other way. Had psychotherapy been effective in the treatment of enuresis psychiatrists would have had opportunities for observing the tremendous improvement in the confidence and well-being of a child who has been cured; one can assess the result of therapy simply by looking at the child's face as he walks into the consulting-room.

Since publishing my series of 100 children treated with the buzzer up to 1958¹ my out-patient clinics have been inundated with enuretics, and the results to date of completed cases personally supervised by me prove the value of the treatment:

Dry	330	(74%)
Improved	40	(9%)
Wet	75	(17%)
Total	445	

In addition, the result was unknown in 33 cases and 36 required refresher courses for relapses. Many others have been passed on by me to welfare clinics in Essex from whence it has been possible to borrow a buzzer in the last two or three years, but their results have not been collected. In Middlesex these facilities are still not generally available.

There are still many who, for one reason or another, fail to treat these miserable children; that about 75% of them can rapidly be dried up by this simple apparatus should dispel any doubts that remain.—I am, etc.,

IAN G. WICKES.

Stock, Essex.

REFERENCE

- ¹ Wickes, I. G., *Arch. Dis. Childh.*, 1958, 33, 160.

SIR,—It is refreshing to find a psychiatrist willing to admit that he finds no evidence that enuresis is basically a psychiatric disorder, for the myth that it is dies hard and has delayed progress. However the alternative concept put forward by Dr. R. G. Barbour and his colleagues (September 28, p. 787) that enuresis is a "disorder of development" leaves much to be desired.

In a loose sense enuresis is no doubt a disorder of development: so too are knock-knee, squint, and cretinism, yet the label does nothing to help explain why these occur. Similarly it does not explain why bed-wetting continues year

after year, often for a decade or more, in an otherwise healthy and normal child.

The explanation of its persistence is surely that by the age of 5 years (the youngest age in Dr. Barbour's series) these children have developed a "habit," or fixed pattern of response, whereby they allow the bladder to empty itself night after night with little or no control from the higher centres. Every time this occurs the pattern is reinforced, thus helping to ensure that it will continue to do so. It is, in fact, self-perpetuating, needing no external factors, physical or psychological, to keep it going. Little wonder then that Dr. Barbour could not find these factors, for they do not exist.

External factors (e.g., illnesses and emotional stresses) do, of course, play a significant part at the outset of enuresis,² but this is outside the scope of our present discussion.

Dr. Barbour states that "the disappearance of this symptom is dependent more upon age than therapeutic intervention." This must be firmly refuted. By means of electric alarm therapy the habit of bed-wetting can be broken in the majority of cases. In a matter of weeks results are obtained equal, and in many ways superior, to those reported by Dr. Barbour and his co-workers in their follow-up five years after their initial assessment. It is therefore no longer justifiable to allow this depressing condition to linger on throughout childhood without at least offering the sufferers the chance of a quick and speedy relief.—I am, etc.,

T. H. GILLISON.

Ikeston, Derbyshire.

REFERENCES

- ¹ Cust, G., *Lancet*, 1958, 2, 1167.
² Miller, F. J. W., Court, S. D. M., Walton, W. S., and Knox, E. G., *Growing up in Newcastle upon Tyne*, 1960. Oxford University Press, London.

Fitness for General Anaesthesia

SIR,—Recently we have encountered several instances where patients requiring emergency procedures involving anaesthesia are unduly anxious. The reason is they have been told by a practitioner, because they are prone to attacks of asthma or are the possessors of a heart murmur, that they should "never on any account receive a general anaesthetic," irrespective of long intervals between attacks or a normal exercise tolerance.

Although appreciating that these sufferers should be aware of their condition, and that they should probably avoid anaesthesia in a dental surgery or out-patients department, we feel that a great deal of unnecessary anxiety is occasioned. There are, we consider, very few absolute contraindications to general anaesthesia provided the exigency is sufficient, and that the patient will ultimately derive benefit from the procedure.

We do not wish to give the impression that intercurrent disease does not increase the difficulty or risk of an anaesthetic, but would emphasize that with intelligent

use of modern techniques these are reduced, and that anyone who tells a patient that he is unfit for any anaesthetic should be in possession of all the facts. In our experience such an opinion, once expressed, cannot be completely eradicated from the patient's mind, and fear can still kill.—We are, etc.,

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Jejunal Biopsy in Childhood

SIR,—In his informative article on "Coeliac Disease in Childhood" (September 21, p. 701) Professor D. Hubble discusses the merits of the various techniques employed for diagnostic biopsy of the small intestinal mucosa. He rightly points out the advantages of the Crosby and Kugler capsule over our own and the one described by Brandborg, Rubin, and Quinton,¹ the two last-mentioned being modifications of Wood's gastric biopsy tube and acting on a pull-wire system. These advantages are easier handling, less screening time, and less mucosal fragmentation.

I find it, however, of doubtful justification to employ a technique which has produced fairly serious complications in close to 4% (three in 80 children) of Professor Hubble's own series, although if the number of biopsies performed by other members of his own group are added this rate would appear to be only 2% (three in 150 children).

The capsule originally designed by Crosby and Kugler² was never intended for paediatric use. The biopsy aperture has a diameter of 4–5 mm., compared to that of Brandborg *et al.* of 2 mm. and our own of 2×3 mm. (oval shaped). The size of the biopsy specimen will depend on the size of this aperture as well as on the amount of negative pressure used to suck the specimen into the biopsy capsule. The Crosby and Kugler capsule uses negative pressure both for sucking in of the specimen and for firing off the biopsy knife, the amount of pressure depending on the release of the knife. In the other two tubes suction is employed solely for drawing the specimen into the biopsy capsule, and the amount of negative pressure required can be carefully regulated by the use of a manometer, thereby adding safety to the method. A third cause of trouble is sometimes due to incomplete cutting by the knife when too large a piece of tissue is sucked into the aperture. The mucosa may thus be "nipped" between the knife and the wall of the aperture. This may happen with all three tubes. However, in the Crosby and Kugler tube control of the knife is lost once it has been released. Thus freeing the specimen can be accomplished only by traction on the tube through the mouth in