

James O'Brien and colleagues' approach was too simplistic.¹

The premise that primary treatment of the symptoms of stress, urge, and mixed incontinence is simple is unfounded. In controlled trials the objective cure rate after pelvic floor exercise in women with genuine stress incontinence is low²; similarly, in women with detrusor instability bladder retraining is associated with a high long term relapse rate.³

In O'Brien and colleagues' study patients were treated on the basis of symptoms alone and no attempt was made to diagnose the cause of incontinence. As the correlation between urinary symptoms and urodynamic diagnosis is poor⁴ many patients will have been incorrectly treated, resulting in an apparent reduction in the efficacy of treatment. It is not surprising that patients with mixed symptoms had the poorest outcome, with only half reporting symptomatic improvement.

Patients who remain incontinent will become disillusioned and may seek no further medical advice, thinking that nothing can be done to help them. It is already difficult to convince patients that most of them can be cured, or their incontinence can at least be improved, by appropriate investigation and management.

The nature and duration of follow up were inadequate; no objective measures of severity of leakage were used, and no assessment of the results of treatment was continued beyond 12 weeks.

We believe that, with few exceptions (notably elderly people), incontinent patients require some basic investigation, often including urodynamic assessment, before treatment. Outcome should be carefully monitored and assessed objectively whenever possible.

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Potassium concentrations in irradiated blood

SIR,—G Dinning and colleagues report increased concentrations of potassium in irradiated blood.¹ The Royal Liverpool University Hospital receives 65% of its blood as SAG-M blood; this blood has virtually all its plasma removed and replaced with an isotonic nutrient solution (saline, adenine, glucose, mannitol).

We measured potassium concentrations in SAG-M blood after irradiation (with 15 Gy). The concentrations were higher in SAG-M blood than whole blood throughout storage (table). After irradiation they increased in a fashion similar to concentrations in whole blood and plasma reduced blood,¹ values as high as those in non-irradiated

Potassium concentrations (mmol/l) in irradiated whole blood and SAG-M blood

	Days after collection			
	9	25	33	35
Whole blood	11	15.3	16	27
Irradiated whole blood	19.5	27.3	32.5	38.6
SAG-M blood	20	30	38	60.5
Irradiated SAG-M blood	30.7	52.5	62	72

blood at its expiry date (35 days' storage) being attained after 15 days' storage. We therefore recommend that any blood, but particularly SAG-M blood, irradiated at this hospital should be as fresh as possible and should be administered as soon after irradiation as practicable, and we do not store irradiated blood for more than 48 hours.

Dinning and colleagues suggest that unused irradiated blood may be cross matched for other patients. We do not recommend this policy for patients who would not normally receive irradiated blood. Luban and Ness outline theoretical risks of such a policy in view of changes to DNA structure and repair induced by irradiation and the possibility of producing sister chromatid exchanges, all of which may predispose to primary or secondary malignancy or chromosomal damage.²

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The health of the nation

SIR,—With regard to the many letters published recently concerning *The Health of the Nation*, may I add that the role of early intervention concerning emotional stress disorder in young children is not mentioned in recent documents on child surveillance that I have read, although the Royal College of General Practitioners states that emotional aspects should always be borne in mind.¹

Major (and minor) adult psychiatric illness is often costly to treat and entails considerable suffering. Studies show connections between childhood psychological problems and subsequent illness. Research shows the considerable value, clinically and financially, of surveillance for emotional disorder in early childhood. The annual research review of the International Association of Child Psychology and Psychiatry (of which I am southwest chair) describes some of these studies.² For example, an esteemed unit in New York described early intervention in infantile autism as successful. (Lack of eye contact between mother and infant was one diagnostic item.) Studies from Scotland indicate that the value of postnatal counselling by a health visitor diminishes the need for antidepressants.³

Recent work by Nicol in Leicester (and Kolvin in Newcastle) indicates the value of different degrees of parent, group, and family therapy.^{2,4} They screened a population and offered treatment for children and mothers with emotional problems rather than treating patients presenting themselves.

Richman's work at the Hospital for Sick Children, Great Ormond Street, shows that a large percentage of children with symptoms at the age of 3 continue to have them at the age of 8.⁵ All children thus "do not grow out of" enuresis, sleep disorders, etc.

I have used a mother-baby interaction scale (valid from birth to 2 years) which could be incorporated in a surveillance document. Often parents are not aware of emotional problems in themselves and their children. At surveillance, problems can be picked up about which parents may not have approached their medical practitioners.^{6,8}

Incidentally, follow up studies show the upset caused by mother-baby separation and long term effects on the physiological and immune systems.⁹

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Endometrial resection or abdominal hysterectomy in menorrhagia?

SIR,—In the past obstetric and gynaecological innovations have been enthusiastically embraced and have become accepted practice without proper evaluation. Disentangling the advantages and disadvantages, as with cervical cerclage, can be extremely laborious. Michael J Gannon and colleagues have made a creditable comparison between endometrial resection and abdominal hysterectomy for dysfunctional uterine bleeding.¹ More than 4000 women have now been treated by endometrial resection, and the authors' honest reporting of the problems that they have experienced with the new method is welcome; several serious, including some fatal, complications have occurred at other centres.

The costings given in the paper do not include costs for either pelvic ultrasonography or repeat endometrial ablation. In terms of relieving symptoms the failure rate of 16% for endometrial resection is high compared with that for hysterectomy.

The authors do not explain why contraceptive advice was based on the presence or absence of cyclical bleeding. Does this correlate with tubal patency? The pregnancy that occurred must be regarded as profoundly disturbing. Endometrial resection is, after all, intended to induce amenorrhoea, and an early pregnancy might therefore be unsuspected. The gestational age at which this pregnancy was detected is not stated. Though the psychological morbidity associated with early termination of unwanted pregnancy is low, a woman who has a second trimester termination after endometrial ablation might well suffer from conflicting feelings. With increasing gestation any consequences of placenta accreta presumably worsen. The postoperative progress after endometrial resection has been carefully assessed, but practice and advice after hysterectomy seem to be based on tradition.

The suggestion that vaginal hysterectomy might be a better comparison for endometrial resection prompted a review of 23 recent vaginal hysterectomies at Prince Philip Hospital, Llanelli, and West Wales General Hospital, Carmarthen. In addition to dysfunctional bleeding pathological findings included adenomyosis, fibroids, cervical intraepithelial neoplasia, and atypical hyperplasia. The operating time was 20-57 (median 30) minutes and the hospital stay 4-9 (median 5) days. At postoperative review four women had pelvic pain or vault tenderness and seven had vault granulation.

This prompted a review of routine practice. A 20 minute technique for vaginal hysterectomy has been described,² as has early discharge after this operation.³ Data corresponding to the criteria used to assess endometrial resection (the duration of bleeding or serosanguinous discharge and subjective assessment of recovery time) will be