Correspondence

Neuropathic bladder and spinal dysraphism

Sir,

We support Borzyskowski and Neville¹ in their plea for early recognition of occult forms of spinal dysraphism. Although experience suggests that it is rare to find lessening of neurological impairment in such patients after surgery, further deterioration may be prevented.

The correct use of the term spinal dysraphism is important; in a recent postgraduate examination a question on spinal dysraphism elicited replies which totally ignored all open forms such as myelocoele. In 1886 von Recklinghausen wrote about the araphic theory in the causation of open and closed spinal defects.² The term dysraphism is derived from that paper, and it was used again by Lichtenstein.³ Other authors, such as Gryspeerdt,⁴ have dealt with lesions including tethered cord and diastematomyelia under the general heading of occult spinal dysraphism or, more correctly, cryptodysraphism (G Crawford, 1981, personal communication). There is growing confusion by the omission of the word *occult*. In their first paragraph Borzyskowski and Neville¹ mention spina bifida as distinct from dysraphism and then cite a reference to occult spinal dysraphism.⁵ We wonder whether a paper by James and Lassman entitled 'Spinal dysraphism'⁶ although clearly dealing with occult forms only, might have increased the misunderstanding.

Unfused neural arches, commonly described as spina bifida occulta, are found in about 5% of normal adults and in some children with delayed fusion;⁷ this radiological finding must be related to other bony lesions—such as a widened interpedicular space, bone spur, or enlarged intervertebral foramen—before being considered significant. However, the presence of neurological abnormalities merits further investigation in the presence or absence of spina bifida occulta.

References

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- 3 Lichtenstein B W. Spinal dysraphism. Spina bifida and myelodysplasia. *Arch Neurol Psychiatr* 1940; **44**: 792-8.
- 4 Gryspeerdt G L. Myelographic assessment of occult forms of spinal dysraphism. *Acta Radiol [Diagn] (Stockh)* 1963; **1**: 702-17.
- 5 Anderson F M. Occult spinal dysraphism: a series of 73 cases. *Pediatrics* 1975; **55**: 826-35.
- 6 James C C M, Lassman L P. Spinal dysraphism. An orthopaedic syndrome in children accompanying occult forms. *Arch Dis Child* 1960; **35**: 315-27.

- ⁷ Lorber J, Levick K. Spina bifida cystica. Incidence of spina bifida occulta in parents and in controls. *Arch Dis Child* 1967; **42**: 171-3.

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Dr Neville and Dr Borzyskowski comment:

We accept that the term spinal dysraphism should be used as the term for all midline fusion defects of the spinal cord. However, it has become conventional to separate open spina bifida from the closed fusion defects with significant neurological lesions. The letter from Dr Levick and Mr Sharrard points out that this view is appearing in examination answers. Several authors have used this terminology for closed lesions with significant neurological defect, and occult spina bifida or occult spinal dysraphism may be confused with the minor degree of non-fusion of L5 or S1 neural arches. The first sentence of our paper should have read 'The causes of a neuropathic bladder in childhood are numerous, and include open spina bifida (which forms the largest group), closed spinal dysraphism, spinal cord tumour, trauma, and myelitis.' We welcome the writers' support for the need for early recognition of such patients in whom the external manifestations are often quite minor.

Nursing sick children

Sir,

Your Annotation¹ was both timely and encouraging. For years we have been trying to gain recognition of the importance of meeting the needs of children by utilising existing trained staff and by maintaining or re-establishing training facilities for sick children's nurses. Despite the highly commended Court report,² little progress has been made in implementing its recommendations. This is because there is resistance to change, particularly on the part of those who have the power to initiate it but who have failed to understand the relevance of such change in the light of growing emphasis in child care.

Paediatric nurses in Scotland have some support (but it is not known for how long) from the Scottish Home and Health Department and the General Nursing Council for Scotland, to the extent that some semblance of a training scheme for nurses specialising in the care of sick children has been retained. However, we feel that the time has come for our case to be represented far more strongly at EEC level because the pattern of nurse training is greatly influenced by the EEC Committee. As a nurse teacher I know that the existing programme for student nurse