Dr Clayden comments:

I would support Mr Guha in his defence of the librarians' future. I was merely suggesting in my brief article that the library as a place might disappear. The librarians' role of custodians of information systems and experts in retrieval is already taking over from the role of guardians of books. We should not lose sight of the liberation from memorising facts which the accessibility of massive databases is increasingly allowing. I would imagine most patients would prefer their doctor to be expert in using data to solve their problems than merely being able to retrieve from their own memories the list of facts about a particular illness. Similarly, the librarian who is expert in retrieval of information is more vital than those expert in the effect of climate on the degeneration of books and manuscripts. It is inevitable that I should use a journal to communicate my opinions at this stage as the availability of electronic newswires has been priced out of the market so far. Similarly, I cannot imagine that Bell attempted to phone his friends about modifications to his invention in the early years either.

I cannot agree in the long term with Mr Guha's anxiety about the developing world. An out of date book is perhaps as dangerous as no book at all. How many remote areas of the world are unable to receive radio broadcasts now? It is therefore easy to foresee the future of sonar powered computers receiving satellite transmitted signals to update databases and expert systems through the world.

On the personal side, I may have to admit to an early fear of books bred (or it is bread) as a result of a degree of dyslexia in childhood. Although the telephone and word processor may be our mode of communication, I welcome the humanity which shines through these contacts by friendly and supportive librarians as much as Mr Guha and I will value that of the future doctors into whose hands we will inevitably fall. Let us hope that their kindness and wisdom are also strengthened by all the powers of science and technology available in that hopefully distant time.

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The frequency of chronically holding the urine to the last minute, or urinary tract infection in children with squating (results are number (% of children)

| Frequency | Present series | Hellström et al.
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<tbody>
<tr>
<td></td>
<td>(n=16)</td>
<td>(n=41)</td>
</tr>
<tr>
<td>Chronic holding of urine</td>
<td>11 (69)</td>
<td>18 (44)</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>12 (75)</td>
<td>15 (37)</td>
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Squatting and urinary tract infection

Sir,—We read with interest the article by Hellström et al on the association of urinary symptoms and previous urinary tract infection.1 Hellström et al found urinary tract infection in 15 (37%) of 41 children with squating. We agree that urinary tract infection is common in children with squatting.2 In the past 22 months we identified 16 children who presented with squatting at least once per week. The average age at our assessment was 77 months, range 47 to 126 months. There were 15 girls and one boy. The table shows the frequency of chronically holding the urine to the last minute and urinary tract infection in these children. None of the children had enuresis, a gait disturbance, a palpable defect in the lumbosacral spine, or an abnormal neurological examination.

Nine of the 16 series had either a retrograde voiding cystourethrogram taken or cystoscopy performed. Four children had mild vesicoureteric reflux, two had trabeculated bladder (one also had a bladder diverticulum), and one had urethral stenosis. Only two children had normal results on these studies and both of these children had a history of chronically holding the urine to the last minute. Four of the five children who did not hold their urine to the last minute had abnormal results on the studies.

Hellström et al questioned whether symptoms of bladder dysfunction or urinary tract infection come first and whether they develop in a causal relationship. We believe that both urinary tract infection and squatting develop consequent to a number of clinical conditions including chronically holding the urine. In the last minute, detrusor sphincter incoordination, or urethral obstruction. Chronically holding the urine to the last minute may become a habit in some children and should be differentiated from children with urgency who do respond promptly to the signals of the need to void. In the former case, parents typically observe these children dancing around, fidgeting, or holding themselves, whereas in the latter case, the sensation comes on suddenly without any warning.

Instructing children to respond promptly to the signals of the need to void, take their time to completely empty the bladder, and void at least every two hours during the day should be part of the treatment plan for children with either urinary tract infection or squatting.

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Gastro-oesophageal reflux and the lung

Sir,—I read with great interest the annotation by Professor Simpson and Dr Hampton about the inter-relationships between respiratory disorders and gastro-oesophageal reflux.1 The authors did not mention an important group of children in whom respiratory disease and reflux may coexist, namely those with cystic fibrosis. The association between these conditions first came to light in 1984 when two children were reported in whom gastro-oesophageal reflux disease with recurrent aspiration had been diagnosed, but who were subsequently discovered to have cystic fibrosis.2 A large scale, prospective study of the incidence of reflux in cystic