77

BRITISH MEDICAL JOURNAL

SATURDAY 16 SEPTEMBER 1972

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NO. 5828 BRITISH MEDICAL JOURNAL 1972 VOLUME 3 655-712 ASTM CODEN: BMJOAE 3 (5828) 655-712 (1972)
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR TELEPHONE 01-387 4499 WEEKLY PRICE 42p

CORRESPONDENCE

Correspondents are asked to be brief

Regional Hospital Staffing

SIR,—Four years ago the Department of Health and Social Security imposed an embargo on the creation of new appointments at registrar level. As a consequence some responsibilities of registrar level are now being covered by senior house officers and requests to appoint registrars in new or expanded units are refused.

During this period appointments at senior registrar level have increased by 25% but almost entirely outside the regional hospitals.[1] Over the same period there has been a 43% increase in senior house officer appointments, but in our view this does not provide adequate experience for the safe care of patients.

This action is jeopardizing the safe and efficient running of some departments in regional hospitals and of new or expanded units. Consultant cover for these units is obtained either by appointing new consultants or by increasing the work load of existing consultants. We feel it is dangerous and unrealistic not to appoint at the same time resident junior staff of sufficient experience, as they are likely to be the only ones immediately available when any emergency arises: the only suitable junior staff fulfilling these criteria must be of registrar status or above.

The 506 members of the Regional Hospitals' Consultants and Specialists Association who have signed this letter have personal experience of this problem and wish to point out strongly the dangers of trying to run a department or unit where emergencies are likely to arise without suitably experienced junior staff. The distribution of the signatories among the specialties is as follows: general surgery, 144; anaesthetics, 76; general medicine, 76; psychiatry, 49; obstetrics and gynaecology, 87; orthopaedics, 23; paediatrics, 13; pathology, 11; E.N.T., 11; radiology, 10; plastic surgery, 1; venereology, 1; ophthalmology, 3; geriatrics, 1.—I am, etc.,

R. BROWNLOW MARTIN,
Executive Officer,
Regional Hospitals' Consultants and Specialists Association
Ascot, Berks

1 Department of Health and Social Security, *Digest of Health Statistics*. London, H.M.S.O., 1971.

**The names of the 506 consultants and specialists in England and Wales who signed this letter appear on advertisement page xviii.—ED., *B.M.J.*

Renal Agenesis and Pulmonary Hypoplasia

SIR,—The association of bilateral renal agenesis in the newborn infant with a characteristic facial appearance is well known.[1] Pulmonary hypoplasia is almost always present in these infants,[2] and both this and the facial appearance are believed to result from the characteristic deficiency of amniotic fluid due to the renal abnormality. Severe renal malformations not amounting to agenesis may also be associated with pulmonary dysplasia, often complicated by pneumothorax and pneumomediastinum.[3] The frequency of absence of kidneys and related gross renal congenital anomalies is given as 0·3% of all still-births and deaths up to 6 weeks of age.[4]

Only half the cases of renal tract malformation are associated with the typical "Potter facies."[3] A gross congenital renal anomaly may therefore not be readily identifiable by the facial appearance at birth but the baby may still suffer from pulmonary dysplasia.

While providing a neonatal resuscitation service for a maternity unit (4,500 deliveries yearly) we have seen in the past two years six babies, all later found to have a gross renal anomaly, who failed to establish respiration spontaneously and whose lungs did not expand adequately with the normal pressures used in neonatal resuscitation—that is, 40-50 cm water.[5] At necropsy all these babies were found to have pronounced pulmonary hypoplasia in addition to their renal anomalies. Three had pneumothorax and pneumomediastinum. One of them was at first thought to have congenital heart disease, but this was disproved by cardiac catheter studies. Only two of the six babies had an abnormal facial appearance, and only one (see Fig.) could thus confidently be recognized as a case of Potter's syndrome.

The following points arise from our experience. Firstly, a diagnosis of severe congenital renal anomaly should be considered in babies who despite the endotracheal tube being correctly placed, require excessive pressures to expand their lungs during resuscitation. Secondly, only a proportion of babies with congenital renal anomaly and pulmonary dysplasia show a characteristic facial appearance: its absence does not exclude the diagnosis. Thirdly, these cases