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Correspondents are asked to be brief.

Importance of Casualty Departments

SIR,—The present dearth of doctors in our casualty and accident departments is a cause of considerable worry to those of us who are responsible for running them.

These departments are unpopular among young medical men. The work there can be arduous and does not provide a definite step forward in the training for any existing specialty in our Health Scheme. This is a pity, for much interesting clinical material passes through the casualty and accident sections each day, and the very diversity of the work is stimulating—the injured eye, the poisoned child, the fractured tibia, together, unfortunately, with all the trivia which should really not be there because they do not require any of the sophisticated facilities that the modern casualty and accident department can provide.

The orthopaedic surgeon is often asked to take charge of these departments, because it is argued that a large proportion of the cases consist of injuries to the locomotor system. This is in many ways unsatisfactory, for such a busy man can rarely spare the time to be on the spot long enough and often enough to be of use when he is most required, and his expert and somewhat narrow training are inappropriate to many of the problems that present themselves.

The type of doctor required to preside in our casualty and accident departments should, of course, be an expert resuscitator. He should be able to diagnose many conditions with some accuracy and to know which of these to treat himself and where to transfer the other ones as quickly as possible. He should, in some degree, be a "Jack of all trades and Master of none," but a special interest in hand surgery or the care of head injuries might well broaden his medical horizons as well as being of considerable practical use.

The development of such skills as I have suggested is not easy and a career structure to develop them is necessary, together with the prospect of posts carrying a suitable status and financial reward when the training is completed. The situation has deteriorated rapidly in the past few months and may get worse. I write, not to dramatize the subject, but to draw attention to the increasing urgency of the problem.—I am, etc.,

ALAN E. BREMNER.

Newcastle upon Tyne.

Shortage of Casualty Officers

SIR,—I am not of the persuasion who ever seeks to impose longer periods of hospital training on new doctors, particularly as I suspect it is often a way of providing cheap medical labour to subsidize the under-financed hospital service, but I heartily agree with Dr. D. K. Guha-Ray (26 September, p. 774) on the value of experience as a casualty officer.

The casualty department confronts a doctor with the worst that disaster, disease, and human nature can provide, but with facilities and help at hand. When he has learned to deal with it in casualty he is not likely to be disconcerted by it later on in broader fields of medicine.

Before entering general practice I served in the Royal Navy and Merchant Marine. I cannot imagine how I would have coped without the tricks of the trade I learned in only six months as a casualty officer. Nearly always, no matter how bizarre the surroundings or meagre the facilities, one had "seen it all before" in casualty and one got on and did the best one could with what one had.

It is the most valuable halfway-house between the ward and the world, no matter what a doctor intends for his future practice.—I am, etc.,

J. J. NICHOLAS.

Southampton.

G.P.s and Casualty Departments

SIR,—In view of progressive closure of casualty departments in various parts of the country owing to staff shortage, would not this be a suitable opportunity for general practitioners to man these posts when required, and thus maintain their hospital connexion?

This should appeal to younger general practitioners, and might only mean one evening per week. I am sure it could be a workable scheme, and I put it forward for what it is worth.—I am, etc.,

J. W. MITCHELL.

Luton, Beds.

Undiagnosed Abdominal Pain

SIR,—Your leading article on recurrent abdominal pain (22 August, p. 415) is a suitable reminder that in children an organic cause is found in less than 10% of cases. Despite energetic and increasingly accurate diagnostic techniques improvement is slow. In 1951 Conway[1] found serious illness in 5·8% of 250 children attending outpatients at Great Ormond Street with abdominal pain; in Apley's study[2] it was 7%, and a recent survey is in the region of 10%. A proportion of the remaining 90% have an emotional disorder, often depression, which is rapidly benefited by treatment with antidepressant drugs.[3]

The child over five years of age commonly complains of pain in the lower abdomen which may occur many times a week, and may be sufficient to cause it to cry. The pain is associated with nausea but rarely vomiting, there is a feeling of fullness though the appetite may remain normal, and weight loss is unusual. Constipation is often present and on occasions is thought to be responsible for the pain. In addition misery, labile mood swings, and changes in sleep pattern may suggest a depressive illness, though often these symptoms are only elicited by direct