IN THIS ISSUE

Incontinence in hiding

Faecal incontinence is not just a cause for embarrassment. It can also be disabling, isolating and costly. Kalantar and colleagues (*page 54*) report their findings on the Australian prevalence of this largely unrecognised problem, debunking myths that those most affected are the elderly. Kamm's editorial (*page 47*) highlights the common causes of faecal incontinence and updates us on the latest treatment innovations.

Deadlocked

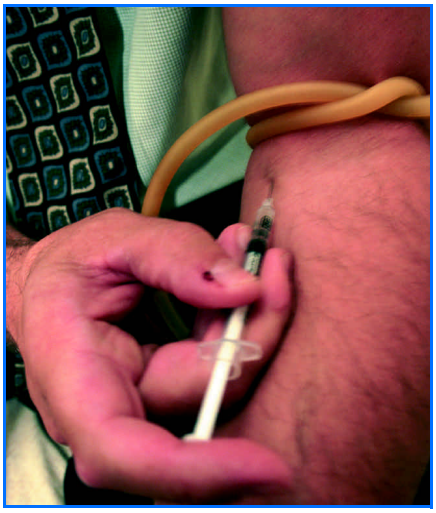
So-called heroin trials, using injectable heroin as part of a maintenance program, have been a bone of contention in Australia, where they have been advocated as a possible form of treatment, but strongly vetoed by the Federal Government. Hall et al (*page 72*) propose an alternative *For Debate:* a trial of hydromorphone, an injectable opioid with similar effects to heroin. Will this break the policy deadlock?

Death lessons

Many of today's medical students may complete their studies without spending too much time inhaling formalin in the anatomy laboratory. They may also avoid the grisly trips to the morgue to witness autopsies. Parker (*page 74*) wonders whether this is a good thing, and discusses the pros and cons of familiarity with the dead body. Meanwhile, Ward et al (*Letters, page 91*) are concerned about falling autopsy rates in their hospital — and forthcoming changes in legislation may exacerbate matters.

Feeling liverish?

The post-festive season is probably not a bad time to contemplate the organ responsible for processing some of our (imbibed and ingested) excesses. Pokorny and Waterland (*page 67*) evaluated liver biopsies performed under radiological guidance and out of hospital. Their findings prompt Griffiths et al (*page 52*) to comment on where and why liver biopsies should be performed, and by whom. Read their conclusions on the role of liver biopsy in an era of revolutionary imaging and laboratory techniques.



Different strokes

Indigenous Australians are admitted to hospital more often than their non-Indigenous compatriots. But what happens to them as inpatients? Cunningham (*page 58*) examined national data on use of diagnostic and therapeutic procedures. In response, Fisher and Weeramanthri (*page 49*) do some soul-searching as to why we treat Indigenous people differently.

What does it all mean?

According to Neuwirth (*page 77*) many doctors are so overwhelmed by the pressures of the "real world" of medicine that we have lost touch with the meaning of why we are there. He gives some tips for reclaiming meaning so that we can all be more effective doctors.

Rocking the boat

The articles on the health of asylum seekers in Australia, published in our recent Christmas issue, have provoked a number of responses, including a critical letter from the Minister for Immigration. Turn to *page 85* for some of these letters and replies.

The end?

A young woman with a young family and an advanced cancer deteriorates suddenly at home. Her husband and parents are in conflict as to what to do next. What does the ethical GP do? For a practical yet thoughtful discussion of the decision-making process, turn to the latest instalment of our *Clinical Ethics* series, by Glare and Tobin (*page 80*).

Bleeding conundrum

When do you refer a patient who is bleeding in early pregnancy? When do you order an ultrasound, proceed to surgery, or offer anti-D prophylaxis? These and other questions on the management of early-pregnancy bleeding were put to GPs, whose responses led McLaren and Shelley (*page 63*) to identify deficiencies in the literature.

A sickle-y story

This issue's *Notable Case* (*page 70*) is the first report of the sickle-cell gene in a Papua New Guinean. A pale, four-year-old boy admitted to hospital in Papua New Guinea with left upper quadrant pain is found to have sickle-cell/β^+-thalassaemia. The sickle-cell gene is later traced as the genetic legacy of a great-grandmother who had come to PNG as a missionary and married into the local community.

Another time ... another place ...

The impartial knife of the pathologist is a certain antidote for conceit. Without autopsies, the natural tendency is to develop a blind confidence in one's habitual methods . . .

W F Putnam, N Engl J Med 1941; 224: 324-328