mingham Revision. Units of energy and pressure are given according to the SI system. This alone makes it unique.

My limited experience of vocational trainees has led me to believe that they often need satisfaction in a specific clinical sense. Just recently, for instance, everything else was set aside to discover what the consultant had meant when he wrote, "This patient is obviously suffering from Frey's syndrome".

The scope of the dictionary is enormous, and the difficulties involved in its compilation are beautifully expressed by the Editor-in-Chief in his preface:

"Avoiding all sensitivity to their alluring colour, the editor of a medico-scientific lexicon now finds himself confronted by the power of words, the tyranny of words, their not infrequent falsity and fickleness, their imposture and their force. At times the lexicographer has to assume the mantle of metalanguage and to sit in judgment outside the arena of word-spinning."

How well he has done his work can be seen if one opens it at any page. To do this is to be fascinated by the diversity of medical and cognate subjects, and the possession on one's lap of the greatest concentration of medical scholarship in existence. Candidates waiting to appear before committees, and waiting in libraries, should be cautioned against becoming too absorbed in it, and should choose something less impressive. It is, in any case, the same weight and size as the old family Bible.

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Sir,

I am grateful to Dr M. K. Thompson for his defence of Butterworth's *Medical Dictionary* and he is certainly right to emphasize its scope and the fact that it is beautifully produced.

Nevertheless, several of the terms in the dictionary are defined in ways not now currently used in British general practice. For example 'consultation' is defined only in terms of a meeting between two or more physicians. Similarly a 'group', which is now one of the more important developments in vocational training and continuing education, is defined only in terms of inanimate objects.

In the list of abbreviations at the beginning, while fellowship of the College is acknowledged neither membership nor the College itself are given a place, whereas all the other Royal Colleges are listed in the appropriate groups.

I believe that a dictionary costing £45 and of almost 2,000 pages, if it is to be acceptable to our branch of the profession, should help vocational trainees to define common terms used in their discipline. Personally I think 'collusion of anonymity' is just the kind of term which a trainee might legitimately expect to have defined as it is now a common idea in general practice.

All the following are currently in use in this *Journal* and in standard general practice works and yet are omitted from this dictionary: A4 records; ANC 1,2,3, forms; local authorities: a) regional health authorities (RHA), b) area health authorities (AHA); age/sex register; assessment; Balint/Balintology (individual doctors are listed by names); consultation rate; course organizer; diagnostic register; district management team (DMT); E book; educational objective; family practitioner committee (FPC); family practitioner services; General Medical Services Committee (GMSC); general practitioner; group practice premises; health centre; health visitor; independent contractor status; practice nurse; probability; regional adviser; role; social class categories 1,2,3,4,5; social services department; trainee; vocational training.

This dictionary could be valuable in postgraduate medical centre libraries, but I regret I am still not able to recommend it for practice libraries or for vocational trainees.

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ROLE OF ACUPUNCTURE

Sir,

Having several years' experience with acupuncture, and over 20 years in general practice, I am in complete agreement with Dr Sheehan's letter (February *Journal*, p. 119). Surely it is time for the profession to have a balanced approach? The over-enthusiastic claimants for acupuncture do almost as great a disservice as the closed minds who dismiss it, without experience, as "having no logical basis". Of course, acupuncture is not a panacea and will never replace Western medicine and surgery. However, it can, and often does, prove most useful and effective when conventional methods are not helping, for example in the conditions which Dr Sheehan mentions.

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ABDOMINAL PAIN IN CHILDHOOD

Sir,

Dr Turner's article, "Recurrent abdominal pain in children" (December *Journal*, p. 729) is a most interesting piece of general practice recording. Like all good research, this paper raises more questions than it answers.

The almost total absence of a clear diagnosis in 162 of these cases appears to lead to the conclusion that recurrent abdominal pain in children is the product of psyche and the environment. The current medical euphemism is 'non-organic disease'. This is more acceptable but no more helpful than 'imaginary'. What else is non-organic?

The problem of the aetiology of abdominal pain is not confined to the recurrent pains of childhood. In a series from Leeds of 600 acute abdomens, 100 were labelled 'non-organic disease' (Staniland *et al.*, 1972).

Only work in general practice can resolve these puzzles. General practitioners have the unique opportunity of listening to the patient's original story before it has been modified by the development of some parts and the discarding of others.

It is obvious that we need to expand our concepts of the aetiology of abdominal pain beyond the sets of surgical pathology. One way of doing so is to consider the role of segmental pain reference in these cases. I have found this extremely useful. Musculo-skeletal disorders appear to be a main cause of abdominal pain in my practice.

I wonder if other of your readers have a similar view.

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Reference

Staniland, J. R., Ditchburn, J. & Domdal, F. T. de (1972). Clinical presentation of acute abdomen. *British Medical Journal*, 3, 393-398.