The frequency of subclinical infection is at this stage difficult to project. Testing of "normal" sera with a rather arbitrary haemagglutinating antigen² may unearth antibody but, if there can be antigen sharing among Gram-negative organisms its specificity may also be in doubt. In the end there has to be some relation to the clinical disease. Another survey³ of over 2000 persons from various population groups in the Nottingham area, which has experienced the disease, showed antibody as measured by specific fluorescence in only 31 (1.5%).

Rapid identification of legionella from patient material is very necessary. Bacteriological methods of culture have been described⁴ and further selective media are under study.

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¹ Grady, G F, and Gilfillan, R F, *Annals of Internal Medicine*, 1979, **90**, 607.

² Edson, D C, et al, *Annals of Internal Medicine*, 1979, **90**, 691.

³ Macrae, A D, Appleton, P N, and Laverick, A, *Annals of Internal Medicine*, 1979, **90**, 580.

⁴ Greaves, P G, Sharp, G, and Macrae, A D, *Lancet*, 1979, **1**, 551.

Drugs for pain

SIR,—Dr L Lasagna (4 August, p 333) expressed some views about morphine which overlook the extensive British literature and experience with this drug.

For severe cancer pain—the commonest reason for using morphine in this country—we treated 250 patients with morphine last year. One hundred and eighty of them never needed more than 40 mg four hourly by mouth. To give a drug which is so potent by mouth parenterally would cause patients much unnecessary discomfort. Indeed, of the last 400 patients to die in our care, only 160 ever needed any injection of any kind. The majority were able to take oral medication to within four hours of their death. Properly used, morphine does not cloud the consciousness of these patients.

As Dr Lasagna indicates, the cook-book "Brompton cocktail" approach to the care of such patients is also outdated.

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Care of children in general practice

SIR,—Dr Stuart Carne, in his article on "Care of children in general practice," (21 July, p 190), appears to have failed to understand the principles of developmental assessment of infants and small children.

Assessment must be done at definite intervals; if the child is well and therefore does not visit his general practitioner, congenital defects such as deafness and squints, speech defects and motor retardation may be missed until well after the optimum time for treatment. A visit for otitis media is most inopportune for testing hearing. Examination of hips for congenital instability needs to be done at intervals, such as 6 weeks, 6 months, and 1 year, and not just on the occasion when the baby has nappy rash. Complete checks for a developmental assessment should never be

carried out on a child with intercurrent illness as an ill child will not show interest, drive, or response.

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SIR,—I read with interest Dr Stuart Carne's article (21 July, p 190), "The care of children in general practice," in which he argued cogently that it was in general practice that experience and expertise lay. In his hands I am sure that it does. Nevertheless, his admission that very few handicapping conditions occur in each practice is surely one that cannot be glossed over lightly. It is precisely in this field that the community doctor, whom he scarcely mentions, can offer much help and expertise, not only to the child but also to his family.

We in community medicine see considerable numbers of handicapped children and build up experience and knowledge of their problems. We add this to our roles in preventive medicine and child development. It is not enough to note in passing how a child is progressing. It needs a careful monitoring programme not to miss the potentially damaging degrees of developmental delay, visual and hearing loss, and educational anomalies.

It is often now the senior community staff who can and often do offer training in development and handicapping conditions to the general practitioners in their patch. Where this happens and where other doctors, in both general and hospital practice, are aware of community expertise there is no talk of dismissing the service as irrelevant. Maybe clinical medical officers would do well to learn this lesson and concentrate on perfecting and sharing their skills with their colleagues rather than to complain that they do not enjoy a well-defined place in the NHS structure.

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Neonatal superintensive care

SIR,—The article by Dr Malcolm Chiswick and others (28 July, p 247) gives me the opportunity of expanding the figures for mortality in babies of very low birth weight reported elsewhere.¹

Figures from Hammersmith Hospital² showed that there had been no improvement in survival rates in those infants weighing 1500 g or less born and treated in that hospital from 1961 to 1975. Now Dr Chiswick and his colleagues give their figures for babies imported to St Mary's Hospital, Manchester, in the years 1976-8. From their table I it can be seen that, of the 73 infants in this weight group, 32 survived—a mortality rate of 56.2%. My table shows this figure along with that for Hammersmith Hospital in 1971-5 and compares both with the national results in the

Percentage of neonatal (0-28 d) deaths in babies born weighing 1.5 kg or less

Completed years	Born and treated in Hammersmith Hospital	Imported into St Mary's Hospital	England and Wales
1971-5	51.9		53.9
1976-7		56.2	48.7*

*England only.

same years. It can be seen that the national figures are at least as good as those of the two superintensive care units.

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¹ Gordon, R R, *Lancet*, 1979, **2**, 36.

² Jones, R A K, Cummins, M, and Davies, P A, *Lancet*, 1979, **1**, 1332.

Travel and health risks

SIR,—The rising numbers of cases of imported malaria in Britain, reported in several recent issues of the *BMJ*, reflect an enormous increase in movement from one country to another by air, now measured in hundreds of millions of people annually. It is probably also a response to malaria becoming a notifiable disease. However, I believe the most important factor is that the profession has become much more alive to the problems of imported disease.¹⁻³

Unfortunately, the growing awareness of the profession is not matched by the general public, who remain almost totally ignorant of the medical risks of travel abroad—mostly trivial but sometimes serious, even fatal. I blame this ignorance largely on the travel agents and to a lesser extent on flight operators and others associated with travel. Apart from seeing that the recommendations of the international health regulations are carried out most agents do very little, although detailed information for particular countries is easily obtainable from regularly produced publications by the World Health Organisation and other bodies or by consultation with embassies and high commissions.^{4,5}

Travel agents are supposed to be issued officially by the Department of Health and Social Security with the pamphlet *Health Protection: Notice to Travellers*, which covers the main medical problems of travel and includes a warning about malaria. (I say "supposed" because on one occasion we telephoned most of the Liverpool agents and only one knew of the pamphlet and had it. It would be interesting to discover whether your readers have better luck with their agents). The absurdity is that, although the agent is issued with the pamphlet, he has no legal responsibility to disclose its contents or give a copy to the intending traveller. This should be mandatory. I agree with Dr A P Hall that legislation is needed, even an Act of Parliament.⁶ I wish him luck. Such matters have been raised several times in the House, with the usual equivocal parliamentary responses.

The airline operators are doing much better. Of these, I have always found British Airways and its predecessors the most understanding and helpful.⁷ Today, for instance, warnings about malaria are announced by the hostess in the cabin, both when approaching and when returning from a malarious endemic area; and passengers are advised to see a doctor if they become ill after return and tell him their recent geographical history. Lavatories in the intercontinental terminal in Heathrow now display signs offering similar advice. Equivalent notices should be placed in every major airport in the world, not only in lavatories but wherever the public and the authorities are likely to meet—for example, in the customs and passport areas.

DHSS has printed a small single sheet (Form Part 35) warning against malaria. This fits the folders provided by banks for traveller's