balamin seems remote, unless the sensitivity is to other components. Why not, then, abandon the less safe, and less effective, of two equivalent and equally priced preparations, other than for commercial reasons?

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*Dr Davidson sent a copy of his letter to Dr A H Goodspeed, medical adviser to Glaxo, whose reply is printed below.—Ed, *BMJ*.

SIR,—I am afraid that Dr Davidson has also missed my point, which is that, while he is suggesting that cyanocobalamin should be withdrawn because occasional patients with cyanide toxicity syndromes may be harmed by its use, there are occasional patients who do display hypersensitivity following the administration of cyanocobalamin or hydroxocobalamin. For example, I am currently awaiting further developments in a case of "brisk anaphylactic reaction" to hydroxocobalamin which occurred earlier this year in Scotland. This is the second case of hypersensitivity to hydroxocobalamin of which I have learned this year. As I said in my previous letter, we have no reports of cross-sensitivity between the two cobalamins so far, and since the other constituents of both marketed preparations are identical I am afraid that sensitivity to one cobalamin is not so remote as Dr Davidson would seem to suggest.

So, again, why should cyanocobalamin be withdrawn simply because some doctors do not apparently read data sheets? And can Dr Davidson suggest an appropriate course of action for the above cases of hydroxocobalamin hypersensitivity which have actually happened other than to transfer them to cyanocobalamin, which he would have us withdraw?

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Treatment of tumours in children

SIR,—The paper by Dr E L Lennox and others on the treatment of nephroblastoma (8 September, p 567) serves to illustrate very clearly how important it is that children with cancer should be treated in centres specialising in paediatric oncology, and that their therapy should be given following well-defined protocols. The results achieved in the first Medical Research Council nephroblastoma trial, quoted in that paper, are somewhat out of date now; and the second trial organised by the Working Party on Embryonal Tumours in Childhood closed last year. The interim results of the second trial show survival rates of 90% for all children with disease confined to the kidney or with local or regional nodal spread—that is, without distant metastases.

Despite the remarkable improvement in survival achieved for children with Wilms's tumour there are still many who do not benefit from these advances, either because surgery is carried out by individuals not regularly concerned with treating cancer in children or because the radiotherapy and chemotherapy given after surgery do not follow the modern accepted guidelines. Children are still seen whose tumours have

been removed though loin incisions, making accurate staging impossible.

The United Kingdom Children's Cancer Study Group, which has been established to enable interested and active clinicians in the field to participate in therapy programmes for a wide variety of different children's tumours, has just started a new trial for nephroblastoma. It is hoped that all eligible children will benefit from the lessons learnt in previous trials both in the UK and in other countries.

JOHN MARTIN
Chairman

JILLIAN MANN
Secretary

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Clinical photographs of children

SIR,—It is common in clinical meetings to be faced with slides of children without clothes. It seems to me that for anyone to be stood against a wall and photographed in the nude is a potentially degrading and embarrassing thing. I would like to suggest that children should never be subjected to this indignity unless there is a compelling reason for it—and then only with the consent of the parents and, if he is old enough, the child himself.

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Putting children first

SIR,—The international Year of the Child is drawing to a close, and I should like to ask what in particular we as a profession have contributed to this important aspect of social medicine. I read with interest the leading article "Putting children first" (15 September, p 623), but I should like to see more emphasis given to the child before it is even conceived.

Sex education is now a recognised part of the school curriculum and I understand that marriage guidance counsellors are giving helpful instruction to children at the school level. General practitioners, however, have a unique opportunity for enlightening potential parents of the difficulties and problems, often painful ones, of successful family life. If we could convince ourselves, and young people in particular, that the child comes first; that family life is absolutely basic for the welfare of that child; that successful family life is not easy—that in fact it is all the more successful when difficulties, conflict, and even suffering, are part of it, for it is by facing problems together that growth and progress occur—then I believe that we should have made a real step forward. The child is father to the man, but man and woman, boy and girl, are parents to the child. Both of these views are equally true and equally important.

JEAN WEST

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Accidental injury in children and interrogation of families

SIR,—I write in response to the letter from Drs J M English and Patricia A Sutcliffe (20 October, p 1003) on accidental injury in

children and interrogation of families. This is a particularly sore point with my partners and I as in our practice a particularly unpleasant and unhappy case has arisen where the damage done by a social worker interrogating the family was far in excess of any damage that might have been done by parental abuse of one of the children.

Two points caused us considerable pause for thought—the first was that the whole attitude taken by the social workers and those who ran the non-accidental injury register was of guilt until innocence was proved. They have maintained, and still maintain, this attitude, despite exhaustive research and the absence of any cumulative suspicious evidence apart from one child in the family displaying bruises, which are of the normal nature but of remarkable frequency. The second point is the vigour and the persistence of the inquiry. The result of the ill-considered zeal in the particular case has been: (1) depression for father; (2) repeated consultations for support by mother; (3) the removal of a long-term foster child (to that foster child's considerable detriment—this child was not the subject of the original interest); (4) the inevitable knowledge in a small community that this family is the subject of inquiry and the equally inevitable belief by some that there cannot be smoke without fire.

Surely it is time for the pendulum to swing a little in the other direction—for the families to be considered, and for some system to be arrived at where if confirmatory evidence of child abuse has not been forthcoming after a certain while attention is focused away from that family and that family's name removed from the black book. The family in question have been told that they will be the subject of continual supervision and inquiry until the boy is 16 in some 10 years' time. They have also been warned that this will follow them about the country if they decide to move.

NORTH OF ENGLAND GP

Circumcision and cruelty to children

SIR,—I must take issue with Dr J E Oliver (13 October, p 933) who looks at circumcision from a very polarised point of view. As a general surgeon, I am well aware of the dangers, both physical and mental, that surround circumcision, particularly if performed without anaesthesia, but he does not mention the consequences of leaving the foreskin until 16 years of age or such time as the patient decides he wants something done.

I know remarkably little of the natural history of the foreskin; certainly I recognise the extremes, but I cannot predict the outcome of the large group who may or may not later develop paraphimosis or even a ballooning foreskin. In this group the challenge is to assess the advisability of doing a circumcision versus adopting a wait-and-see policy. My own view is that circumcision at 10 days on religious grounds alone cannot reasonably be refused. After this I do circumcision for complications only until the child is dry, around the age of 3 years, because of the dangers of meatal ulcer. Beyond 3 years I have swung towards circumcision rather than away from it, though I still discourage those with a wide opening. My reasons for so doing are that eventual circumcision at a later age entails yet more discomfort and perhaps an absence from school. A paraphimosis with all

that follows must be an awful experience for any youngster and a pinhole meatus can be a real danger to micturition. The main difficulty arises because as the child reaches adolescence nobody looks at the foreskin and few children will be so enlightened that they will seek aid themselves before complications arise. There are many young adults with non-retractile foreskins who first seek aid when sexual intercourse starts, and presumably many who undertake sexual intercourse without skin retraction; but worst of all is the danger of carcinoma of the penis. I have seen four cases in eight years, the youngest in his 40's with regional nodes invaded. All had foreskins and three were unable to retract them.

There is at present absolutely no publicity warning of the dangers engendered by a non-retractile foreskin and unless we, as doctors, start such a programme, we shall be storing up a dreadful heritage for our male children.

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Pregnancy hazards and the child's charter

SIR,—In this International Year of the Child we, as a doctor and a lawyer respectively, would submit to our professions that further consideration be given to the child's charter.

We propose the examination of the possibility of the extension of human rights to the *babe en ventre sa mere*, and to the minor. In our permissive society, as custodians of the law and medicine, we may not be sufficiently mindful of the potential damage to our progeny, and the weakening of the strain of future generations, which could result from our efforts or omissions. Ignorance of the law in civil courts is no excuse, and best intentions for our offspring's health and welfare are no excuse for any maiming, mental or physical, which therapy to mother or child may produce as a side effect.

Ability of a child to sue "by his next friend" was extended in 1976 by the passing of the Congenital Disabilities (Civil Liability) Act 1976, which implemented the Law Commissioners' report of 1974 on injury to the unborn child. The basic principle of liability introduced by the Act is that a child who is born alive but disabled has a cause of action for damage in respect of his disability as if they were personal injuries suffered immediately after birth (see Section IV (iii)), provided that they were caused by either (a) an occurrence which affected one or other of the parents in his or her ability to have a normal child, or (b) an occurrence which affected the mother during her pregnancy or affected her or the child in the course of the birth so that the child is born with disability which would otherwise not be present.

This principle is subject to the qualification that a professional man (for example, a doctor) is not liable in respect of anything he does or omits to do in giving either treatment or advice according to the prevailing professional standard of care (Section I (v)). Equally there is no liability for preconceptional events if before conception the parents knew and accepted the particular risks (Section I (vii)). The question of liability for side effects of a vaccine administered after recommendation by the State (that is, by the DHSS) has not been defined clearly.

It would be no mitigation to claim concern

over the population explosion as an excuse if it were proved that high intake of oestrogen by the mother prior to starting a family resulted in earlier incidence of genital-tract carcinoma in her eventual female progeny.

The child with congenital abnormalities may not condone its mother's complete disregard for immunisation against rubella when she was fully conversant with the dangers of this viral infection in the first trimester of her pregnancy, although the child cannot sue as the law now stands.

History has recorded several examples of deprivation in childhood being the spur to fame in adult life. But it is when we dare to interfere we must be careful. The Congenital Disabilities (Civil Liability) Act demonstrated unquestionably that there are areas in which we must interfere by applying legal remedies to cure the existing maladies. The child has the legal status and the cause of action, albeit essentially retrospective. Should the law interfere a stage further and legislate for a register of progeny at potential risk? Should such progeny be so informed?

Society as a whole and our professions in particular have an obligation to ensure that, so far as possible, a new baby is given a fair chance of survival as a mentally and physically normal person in a stable family environment. Procreation without regard for parental age, family history, and the behavioural pattern in pregnancy is irresponsible and could create suffering and cause inordinate demand on so many resources: indeed a condemnation of our day and generation.

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No raw deal for breast-fed babies

SIR,—Dr Phyllis Cully and others (13 October, p 891) favour early suckling followed by demand feeding in maternity hospitals. While we wholeheartedly support this conclusion we feel that certain points in their paper call for comment.

The formula-fed babies in their study took 160 ml/kg weight feed on the fifth day after birth, compared with 130 ml/kg weight in the breast-fed group. The authors assumed that this lower milk intake in the breast-fed group related to their rigid "clock-feeding" regimen and proposed that the volume of breast milk taken might be improved by instituting demand feeding. Yet the intakes of breast-fed babies in the first five days are still substantially lower than those in bottle-fed infants even in a unit which specifically encourages demand feeding (our own unpublished data). In any case, since it is established that the sucking response of babies given formula milk is different from those given human milk (even with the container standardised¹), surely it is invalid to extrapolate from what a formula-fed baby will take to what a breast-fed baby should take on any specific day post partum.

Why were the breast-fed babies offered 5% dextrose for their midnight feeds? This practice is not welcomed by most mothers (perhaps with the exception of the first night post partum) and must suboptimise the stimulus to lactation. No study of milk flow or weight gain is necessary to support the argument that breast-fed babies should suck at the breast at all feeds. All that is needed is for

mothers to be reassured that it is physiological for lactation to take a few days to become established.

Finally, without suggesting that the formula group were overfed, their pattern of weight gain in the first week (and afterwards for that matter) cannot be taken as reference growth data applicable to breast-fed babies. Everything about the physiology of the two modes of feeding is different, and there is certainly no evidence to suggest that the rapid weight gain of bottle-fed infants in the first days post partum is a good thing.

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¹ Johnson, P, and Salisbury, D M, in *Parent-Infant Interaction*, Ciba Foundation Symposium 33, p 119. Amsterdam, Elsevier, Excerpta Medica, 1975.

Fetal malnutrition—the price of upright posture?

SIR,—In his second contribution to this debate, Professor John Dobbing has repeated his assertion (13 October, p 934) that brain growth accelerates at the end of intrauterine life. This is unsubstantiated by his references and is in disagreement with ultrasonic data.

His own findings on brain weight¹ are based on necropsy data, which are surely very poor material for discussing normal fetal growth however "carefully selected" they are. Further, only about half a dozen of his observations related to the last month of pregnancy. This is far too few to give any precise answer to the question being debated. In any case, neither his scatter diagram nor the undefined superimposed curve supports his assertion. The mathematical transformation of biparietal diameter he uses to prove his point has no value. Firstly, it assumes that brain weight is proportional to the cube of the head circumference minus an amount inversely proportional to it. This model (which, despite his denial, is a fourth-degree relationship) defies any rational explanation. Secondly, the coefficients of his equation were estimated from totally unsatisfactory data. After careful examination of his paper we have come to the conclusion that apparently he did not measure the head circumference of his own subjects but estimated them in some way from the standards of Gairdner and Pearson,² which themselves rely on two different sources. At all events, there is no mention of any such measurements in either of the papers he cites.^{1,3} There also appear to be discrepancies between his figures, his mathematical transformation, and details given in the text.¹

The assertion that the faltering of the biparietal diameter curve would be removed by conversion to volume is not supported by available data. Since the volume of a solid is proportional to the cube of any of its linear measurements, the cube of the biparietal diameter gives an indication of brain volume variation—on the assumption that there is no great change in head morphology. By using the standards of Campbell and Newman,⁴ whose data we agree to be of high quality, it is easy to verify that this indicator is increasing more slowly (that is, decelerating) towards term.

The basic idea (4 August, p 317) that there is an irregularity of growth in the perinatal period will be really proved only by longitudinal measurements of the same variable pre-