tial minority" or "significant proportion" as being a more precise expression.

In any event, it seems unreasonable to suggest that CDCA has a limited role in management of cholelithiasis in general. A substantial number of patients exist who now have the option of non-surgical treatment. Given suitable selection of cases, the expectation of success is high if the patient is compliant. CDCA has been generally available for only 18 months and, while its final place in management of cholelithiasis due to cholesterol stones remains to be defined, it seems self-evidently a major therapeutic advance in this field.

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¹ Maton, P M, *et al*, *Gut*, 1977, **18**, A976.

² Bell, G D, *Prescribers' Journal*, 1979, **19**, 87.

Accidental injury in children and interrogation of families

SIR,—In their letter on accidental injury in children and interrogation of families (20 October, p 1003) Drs J M English and Patricia A Sutcliffe rightly express their concern at the possible distressing effect of an interrogation of families who are suspected of injuring their children. Obviously if the interview is handled in such a manner that it is perceived as a witch hunt by the parents it is strongly counterproductive and can produce only alienation between parents and health services personnel.

In a recent study of all infants aged from 1 week to 2 years reported to the Inner North London coroner as found unexpectedly dead, it was shown conclusively that interviewing the parents, if tactfully undertaken, can prove therapeutic to the bereaved parents. It has helped them to verbalise their fears and has often ensured better relationships with health care providers. On a recent analysis of our data as many as 83% of parents admitted to finding the interview by a suitably qualified member of the community health services helpful to them in coming to terms with their grief.

Although the two cases—that is, suspicion of injury and "cot death"—are not directly analogous they both present delicate situations with a certain degree of similarity in the type of handling required. We feel that our findings can be beneficial to parents both in helping them to assuage their grief and anxieties and in being constructive for building up good future family relationships.

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SIR,—I am writing in response to the letter from "North of England GP" (10 November, p 1220) on non-accidental injury in children. There are many points in this letter which require to be dealt with in much greater detail than is possible in the correspondence columns of your journal.

Firstly, I accept the feelings expressed by the North of England GP and think they highlight some of the difficulties experienced by professionals working with child abuse. I would draw your readers' attention to a recent article by Tuke,¹ in which he outlines similar feelings and I feel makes a useful contribution

on this point. Secondly, the number of official inquiries following the deaths of children who have been abused, the most recent being Daren Clark,² have indicated a need for swift and thorough investigation following receipt of information, with early reference to the central register. These inquiries have also indicated the need for good communication and co-ordination from all agencies involved. Thirdly, the British Association of Social Workers' publication *The Central Child Abuse Register*,³ 1978, which was influenced significantly by a joint working party established by the British Paediatric Association and BASW, incorporates research on child abuse registers together with recommendations for practice. The issues of registration and deregistration are both dealt with in this publication.

Finally, I should like to add that the case outlined would appear not to be a simple case of suspected child abuse but to concern abuse in a home where there was at least one foster child. Obviously, this would influence the decisions made in this particular case.

Social workers and other professionals involved with cases of non-accidental injury to children do need, as Drs J M English and Patricia A Sutcliffe point out (20 October, p 1003), to "be aware of the sensitive nature of their inquiries" as this is in the interest of both the family and the child.

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¹ Tuke, J W, *Practice of Medicine*, 1979, **223**, 369.

² Department of Health and Social Security, *The Report of the Committee of Inquiry into the Actions of the Authorities and Agencies Relating to Daren James Clark*, Cmnd 7730. London, HMSO, 1979.

³ British Association of Social Workers, *The Central Child Abuse Register*. Birmingham, BASW, 1978.

Hyperbilirubinaemia, weight loss, and breast-feeding

SIR,—Dr Phyllis Culley and colleagues (13 October, p 891) have demonstrated that the greater first-week weight loss of breast-fed infants correlates well with a poorer intake of milk in these infants compared with infants fed artificial milk. They attribute this to the rigid feeding schedule practised in their hospital, associated with a strict avoidance of artificial milk supplements in breast-fed infants. In 1975 I noted a high incidence of hyperbilirubinaemia in breast-fed infants at the Grace Maternity Hospital, Halifax, Nova Scotia. At the time the hospital practised a rigid infant-feeding schedule with strict avoidance of artificial milk in breast-fed infants, similar to that described by Dr Culley and her colleagues. I reviewed retrospectively two groups of infants to see whether there was any relationship between mode of feeding, weight loss, and hyperbilirubinaemia.

The first group comprised all the full-term infants with first-week idiopathic hyperbilirubinaemia (arbitrarily defined as a total plasma bilirubin $>255 \mu\text{mol/l}$ (15 mg/100 ml)) born over the two-year period 1974-5. The second group was a random selection of healthy term infants who did not have hyperbilirubinaemia born over the same two-year period. In both groups the degree of first-week weight loss, expressed as the percentage of birth weight, was significantly greater in the breast-fed infants ($P < 0.001$). The study revealed a highly significant difference in incidence of hyperbilirubinaemia with

mode of feeding, being 5.60% in breast-fed infants and 0.64% in artificially fed infants ($P < 0.001$).

Greater weight loss in the breast-fed infants implies less adequate milk intake in these infants, as Dr Culley and her colleagues have demonstrated. It is not clear from my study whether or not inadequate milk intake contributes to the higher incidence of hyperbilirubinaemia in breast fed infants. Certainly inadequate milk intake is not the sole factor, as there was a similar degree of weight loss in breast-fed infants both with and without hyperbilirubinaemia. However, it is likely to be a contributory factor as there is evidence that starvation results in elevated unconjugated bilirubin levels in newborn and adult animals and humans.¹⁻⁴

Hyperbilirubinaemia frequently leads to maternal anxiety, a degree of maternal-infant separation for phototherapy, delayed discharge from hospital, and sometimes cessation of breast-feeding. It would be of interest to know if the more frequent suckling rightly advocated by Dr Culley and her colleagues has resulted in less hyperbilirubinaemia as well as greater milk intake in breast-fed infants.

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¹ Flint, M, Lathe, G H, and Ricketts, T R, *Annals of New York Academy of Science*, 1963, **111**, 295.

² Owens, D, and Sherlock, S, *British Medical Journal*, 1973, **2**, 559.

³ Bloomer, J R, *et al*, *Gastroenterology*, 1971, **61**, 479.

⁴ Wennberg, R P, Schwartz, R, and Sweet, A Y, *Journal of Paediatrics*, 1966, **68**, 860.

Obstetric anaesthetic and analgesic services in Wales

SIR,—Professor B M Hibbard and his colleagues (24 November, p 1363) state that there are no "controlled trials" supporting our view (20 October, p 1002) that there are medical indications for epidural analgesia in labour. Noble *et al*,¹ in a prospective randomised controlled clinical trial, demonstrated an advantage for the baby when the mother had pain relief effected by epidural block rather than other methods. Weeks *et al*² demonstrated the advantages for the second twin and Willocks and Moir³ demonstrated that epidural analgesia is an effective means of managing hypertension in patients in labour.

Of course, it is difficult to prove that epidural analgesia is preferable for breech delivery—there are so many variables—but many obstetricians would choose this form of analgesia, especially when the breech is flexed and the mother is multiparous. Narcotic drugs are particularly dangerous for the premature baby, so surely epidural analgesia is a better choice. Practising obstetricians know that pudendal block analgesia may be inadequate for forceps rotation and delivery of the fetal head; in these circumstances is not epidural block preferable to general anaesthesia? The dangers of general anaesthesia for patients in labour are well known and are recognised by Professor Hibbard and his colleagues. If the mortality rate from epidural analgesia anywhere approached this level of risk the figures would now be evident.

Professor Hibbard and his colleagues have noted the deficiencies in anaesthetic services in Wales. Their remedy is to suggest that women who ask for epidural analgesia should transfer to a regional centre for their confine-

ment. We do not agree. Surely it is better to recognise the importance of obstetric anaesthetic services and improve the services where they are inadequate. Currently the recruitment of doctors into anaesthesia is excellent and the opportunity exists. Unfortunately, medical administrators seeking to save money might misuse the views of Professor Hibbard and his colleagues and block the improvements that are necessary. This is the true importance of the argument.

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- ¹ Noble, A D, *et al*, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1971, **78**, 559.
² Weeks, A R L, Cheridjian, V E, and Mwanje, D K, *British Medical Journal*, 1977, **2**, 730.
³ Willocks, J, and Moir, D D, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1968, **75**, 225.

Airport hygiene

SIR,—Dr T D V Swinscow's letter (20 October, p 999) raises the whole issue of standards of cleanliness and hygiene in public facilities. Among the most striking things to confront the British traveller to Canada are the almost complete absence of litter (for example, in the Toronto subway system) and the uniformly smart and clean appearance of the people who work in the catering trade. It is a rarity in restaurants not to find clean facilities and adequate soap and paper towels. Such things seem the exception rather than the rule in England. Last time I went into the buffet at Victoria Station for a cup of coffee I felt as if I was in a garbage hole. An improvement in these facilities would do far more for the British tourist trade than many other promotional gimmicks currently employed.

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Treatment of chronic paronychia

SIR,—I read with interest the comments of Dr K A V Cartwright and others (17 November, p 1294) on your expert's reply to the questions about the treatment of chronic paronychia. Having been a consultant dermatologist for over 40 years, I have seen a great many of these disabled patients, many of whom have undergone heroic and often very painful therapy without avail. Surely the underlying basic cause is damage to the cuticle, which normally effectively seals the potential space between the nail and the overlying nailfold. This can be damaged by many things—cold in Raynaud's syndrome, as mentioned in the article; heavy manicure; accidental trauma; over-exposure to alkaline cleansing agents; constant immersion in syrup (as in the fruit canning industry); and even the application of adhesive plaster over a period of days, as shown years ago by Dr Howard Whittle; and so on. Cure therefore depends on restoring the normal cuticle. Immersion in water prevents this, but it is quite unrealistic to expect a busy woman to avoid all contact with water for the six to eight weeks required for the cuticle to regrow. I have treated this condition very successfully by explaining the problem to the patient and

then prescribing a nystatin-containing ointment with the instructions that this should be worked into the affected nailfold using the thumb of the other hand every time she is going to get her hands wet. This may be 20-30 times daily, but the time taken to do it is negligible. This is continued until the cuticle has regrown—a period of about six weeks, but longer in patients with the "chilblain" type of circulation.

The cure depends, in my opinion, very largely on having a water barrier in the nailfold rather than on the fungicidal or antibacterial action of the application. Years ago my sceptical friends would not believe that such a simple remedy worked, so before I held my next national dermatological meeting in Oxford I wrote to six patients chosen at random from our diagnostic index, and let my colleagues see the grateful patients—who all turned up cured by this simple method.

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Subsidy of social functions by drug companies

SIR,—At a recent meeting of trainees from the Exeter GP vocational training scheme it was agreed by a majority decision that subsidies from pharmaceutical companies would not be sought in future for trainee-organised social functions.

General practitioners are probably the most vulnerable group of the medical profession so far as the promotional efforts of the drug companies are concerned. In many cases they do not have the facilities for critical discussions with colleagues of the information put forward by representatives and advertisements. Patterns of prescribing change following visits by drug company representatives, and were this form of promotion not cost effective in terms of increased use of the product in question the companies would have to stop investing large sums of money by advertising in this way.

In view of the above points I feel that it is commendable that the move to reject such methods of advertising by drug company representatives should come from a group of GP trainees and that they are leading general practitioners and the medical profession as a whole in this way. This represents an important advance in awareness of the potential problems inherent in accepting pharmaceutical companies' subsidisation of social functions and, to my knowledge, this is the first time that a group of doctors have made such a decision.

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"A Touch of Sensitivity"

SIR,—The *Horizon* programme *A Touch of Sensitivity* not only confirmed our knowledge of the necessity for intimate contact between mother and baby but—a point not mentioned by your reviewer (17 November, p 287)—it also drew our attention to the importance of non-genital touching for a happy marriage.

The marriage counsellor interviewed showed how a couple could reawaken their mutual love by such simple acts as stroking the partner's arm, provided that a point was

reached where the one doing the stroking desired not so much his own pleasure as to give happiness to the other. This brings to mind the constant teaching of Dr John Billings and his co-workers in Melbourne—that love can be fostered between a couple even when genital contact is temporarily ruled out. Since 1964 they have developed and extensively researched the form of natural family planning known as the ovulation method. This relies entirely on the presence or absence at the vulva of cervical mucus, with observations of the changing or unchanging characteristics of the mucus. By these "observations" (some of its users are blind) the days of probable fertility can be discerned. One of the most important "rules" of the method is that on fertile days there must be no genital contact whatsoever between the couple if pregnancy is to be avoided (the use of barrier methods alters the secretions at the vulva). During the past year the World Health Organisation has conducted a survey of the method in five countries.

An *Atlas of the Ovulation Method* and other literature, including reprints of articles published in professional journals, can be obtained from the Ovulation Method Research and Reference Centre of Australia, 86 Wellington Parade, East Melbourne, Victoria 3002.

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Bronchodilator effect of sodium cromoglycate

SIR,—I read with interest the paper by Drs J T N Chung and R S Jones (27 October, p 1033) on the bronchodilator effect of sodium cromoglycate (SCG) in children. Since this phenomenon has not been reported in adults they raise the possibility that children and adults have different physiological responses to SCG.

As an atopic asthmatic I can report a good subjective and objective (as measured by peak expiratory flow rate) bronchodilator response to SCG in doses of 20 mg taken via the "Spinhaler." I thought that I was unique in this way until I recently treated a 19-year-old atopic asthmatic girl who reported that she used her SCG only when she felt wheezy—and was relieved of her wheeze in a short time.

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Rubella vaccination and unnecessary abortions

SIR,—We question the recent advice given by the DHSS that women who have been vaccinated with a live attenuated rubella vaccine within three months of a pregnancy should be considered to have put the fetus at risk of congenital rubella. This ruling undoubtedly leads to a number of unnecessary abortions at a time when indications for abortion are becoming increasingly strict.

We understand that the ruling arises from an American report that live rubella virus was recovered from a fetus when the mother had been vaccinated seven weeks before conception. There is now, however, some evidence to show that the vaccines used in America are not teratogenic. We would like to suggest that the