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-