Recognising child abuse

SIR,—Your leading article on recognising child abuse (29 March, p 881) was not adequate in two respects. Fewer than one-quarter of our child abuse cases in North-east Wiltshire are recognised *solely* by characteristic burns, bruises, etc.

No mention was made of the absolute necessity to *collate* information. There are always alternative explanations for suspicious injuries to (or conditions of) young children. Adequate protection for a child can seldom be ensured, or even facilitated, on the basis of one or two injuries. The police doctor or other expert cannot very often state unequivocally that the damage was due to parental violence or other maltreatment. It is unusual that a family can be offered adequate supervision (to protect the smallest members) by relying solely on clear-cut signs pathognomic of child abuse. The single episode could well be a genuine accident or, at worst, a single snapping of parental control; but for each highly suspicious injury or accident there is likely to be a penumbra of other suggestive detail.

To recognise child abuse there is a need (a) to collate information covering a period of time, this collating process including episodes of neglect and rejection and records of children (often with different surnames) from the family having been taken into care previously, etc; and (b) to collate information which involves any of the 25 or more different agencies which are wholly or partly concerned with child protection. Doctors or other professional people in this field should not allow themselves to be manoeuvred into a position in which, if they are obliged to give evidence in care order or other court proceedings, the entire legal argument hinges on the certitude that one or two "accidents" (or one or two maltreatment episodes) could have been due only to parental cruelty, where all the supporting information which has accumulated on parental unkindness or ineptitude over previous years, or which is known to different agencies, is bypassed or evaded. If they do, only the most blatantly and obviously starved and battered children will be protected.

Your leading article also failed to mention the most easily concealed yet most dangerous parental malpractices—sustained or ferocious shaking of babies or toddlers, possibly associated with suffocatory techniques. The retinal haemorrhages alluded to could presage epilepsy, brain damage, spasticity, blunted intellect, or death—all more serious than your full page of surface injuries.

J E OLIVER

Burderop Hospital,
Wroughton,
Swindon, Wilts SN4 0QA

SIR,—The brief guidelines (15 March, p 775) and your leading article (29 March, p 881) on the diagnosis and provisional management of non-accidental injuries inflicted on children are incomplete in that the problem of poisoning with drugs or other agents was not discussed. Drugs are readily available in most households, and may offer a simple and less readily detected means of inflicting injury than physical assault. Indeed, once drug intoxication has been diagnosed it can prove very difficult to distinguish between deliberate and accidental poisoning, even when it is clear that a drug has been administered by a parent.¹ The

possibility of poisoning with common agents such as ethanol should also be considered, and a fatality attributed to chronic sodium chloride administration has been described.²

Our initial experience in the diagnosis of unauthorised drug administration to children has been reported,³ and a summary of our work load over the period January to June 1979 has been produced.⁴ Although study of these latter data is still in progress, it is noteworthy that active steps were taken to ensure the safety of the child in 14 of the cases of confirmed poisoning. In the main, toxicological investigations were requested because of unexplained or unusual symptoms, or to provide confirmatory evidence of poisoning where there was clinical or circumstantial evidence of drug ingestion. In some cases the child or family unit was already known to the hospital or social services department because of previous "suspicious injury." However, we rarely receive requests to undertake analyses on samples from patients at the time when physical injury has plainly occurred. Pickering¹ has pointed out that the frequency of unauthorised drug administration to such children is unknown, and we would like to repeat his suggestion that comprehensive toxicological analyses should be undertaken in these cases. Positive findings would, of course, provide additional evidence as to the nature of the assault.

We can offer analytical facilities for these investigations to clinicians in the UK and would prefer to receive specimens of blood (5 ml) and urine (20 ml), which should be collected prior to any drug administration in hospital.⁵ It may be possible to undertake adequate analyses using smaller sample volumes, however, and in such cases we should be contacted before specimens are sent.

R J FLANAGAN
GLYN N VOLANS

Poisons Unit,
Guy's Hospital,
London SE1 9RT

¹ Pickering D. *Am J Dis Child* 1976;130:675-6.

² Meadow R. *Lancet* 1977;ii:343-5.

³ Rogers D, Tripp J, Bentovim A, Robinson A, Berry D, Goulding R. *Br Med J* 1976;ii:793-6.

⁴ Flanagan RJ, Huggett A, Jefferys DB, Raper SM. *N Engl J Med* 1980;302:756.

⁵ Flanagan RJ, Saynor DA, Raper SM. *Lancet* 1980;ii:830.

Assessment of fitness for surgical procedures

SIR,—I would agree with the principles in Mr A M Smith's letter (22 March, p 866). Assessment of fitness for anaesthesia is the responsibility of the individual anaesthetist and, while cardiac risk factors are now better understood, prognostications are applicable only to individuals or institutions which have undertaken their own results. The examination and investigations required by the individual anaesthetist depend on his own experience as well as the medical condition of the patient and the proposed surgical procedure.

Ultimately, however, fitness is always relative to the urgency of the procedure and can be viewed in terms of a cost-benefit relationship. Thus uncontrolled hypertension would justify delaying stripping of varicose veins but not an excision biopsy of a suspicious breast lump.

When the risks are higher, as when a patient with a recent myocardial infarction develops obstructive jaundice, then the patient and his relatives should be advised of the higher risks and true informed consent obtained: the standard consent form should probably be witnessed by one of the more senior members of the surgical team.

Anaesthetists working with rational and experienced surgeons should rarely need to be "genuinely convinced that the operation is really necessary." While discussion of the more risky cases is important these surgeons understand and accept the responsibility for advising surgery. Anaesthetists working with such surgeons will then select the optimum anaesthetic from their own experience, and conduct the anaesthesia in such a way as to launch the patient into the postoperative period in the best possible condition.

JOHN J HENDERSON

Division of Anaesthesia,
Western Infirmary,
Glasgow G11 6NT

Weaning and diarrhoea in the Gambia

SIR,—Though welcoming the attention drawn by Minerva (29 March, p 945) to our Gambian work¹ I suspect that she has not fully appreciated that the local foods studied were used to *supplement* the diet of children who were still being breast-fed.

Weaning in our survey community starts at from 2 to 5 months of age and ends, by definition, with the cessation of breast-feeding at 18 to 24 months. The weaning period is one of severe diarrhoeal morbidity and growth impairment.² In effect, the mothers have two options—that of delaying the introduction of weaning foods beyond the usual age, when we have demonstrated a shortfall in nutrients obtained exclusively from breast milk,³ and the option of starting supplementation in early infancy in an environment where weaning diarrhoea is an almost inevitable consequence.

Even when children benefit from prolonged breast-feeding mothers must eventually supplement their infants' diet, often at as early as 3 months of age in developing countries.⁴ How to do so safely remains a major unsolved problem.

M G M ROWLAND

Medical Research Council,
Dunn Nutrition Unit,
Cambridge CB4 1XJ

¹ Barrell RAE, Rowland MGM. *J Hyg Camb* 1980;84:191-202.

² Rowland MGM, Cole TJ, Whitehead RG. *Br J Nutr* 1977;37:441-50.

³ Whitehead RG. *Food Nutr Bull* 1979;1:36-41.

⁴ Waterlow JC, Thomson AM. *Lancet* 1979;ii:238-42.

Second-best prostatectomy?

SIR,—Your leading article "Second-best prostatectomy?" (1 March, p 590) is right in saying things are better managed in Scotland; and you cite the paper by Graham¹ reporting a Scottish transurethral resection rate of 1.5% in 1974. Graham's report dealt only with surgery within the specialty of urology. In the light of subsequent correspondence in the journal (15 March, pp 789-790) pointing out that equally good results for transurethral resection, as indicated by case fatality, are being obtained by general surgeons with a special interest in urology, it may be of interest to compare case fatality by type of prostatectomy for the two specialties. The data in the tables are from the *Scottish Hospital In-patient Statistics*² for all discharges from hospital, including deaths, following prostatectomy for the years 1971-76.

Table I shows that, for all operations together, the fatality rate is slightly (though just not significantly) higher for general