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.

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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.

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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.

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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.

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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

surgery than for urology. This is evidently due to the larger number of suprapubic and unclassified operations in general surgery, which have a higher fatality rate. But for the operations classified as retropubic and transurethral resection the fatality rates are virtually the same as for urology. It is, however, possible that an important proportion of the large number of prostatectomies in general surgical departments categorised as "not elsewhere classified" may have been retropubic or transurethral resection operations. If this were so, the fatality rate for these two operations would be higher than the rate shown for general surgery.

The comparison in table I takes no account of differences in age and type of admission between the two specialties. Ashley and his colleagues³ showed that an important factor in accounting for the higher overall fatality in hyperplasia of prostate admissions and subsequent prostatectomy in regional hospital board hospitals than in hospitals under boards of governors was the higher proportion of unplanned admissions to the regional board hospitals. In addition to being presumably more seriously ill than the patients with planned admissions, unplanned admission patients tended to be older and less fit. Table II shows for hyperplasia of the prostate, for the two three-year periods 1971-73 and 1974-76, the difference between departments of urology and general surgery in the percentages of patients over the age of 75 and of emergency admissions, as well as the fatality rates in these types of admission. There is a much higher proportion of emergency admissions to general surgical departments and these cases carry a higher fatality rate than that for all admissions. The over-75 patients also have a relatively high hospital fatality rate and there are proportionately slightly more of them admitted to general surgical departments. These two factors probably account for the higher fatality rate for all admissions to general surgery (a difference which reaches statistical significance for the six years combined).

It is interesting that there is no significant difference in either specialty between the Scottish hospital fatality rates for hyperplasia of the prostate discharges and those for prostatectomy discharges. In the series of Ashley and his colleagues the fatality rate for

teaching and regional hospital board hospital together was 4.3% for all admissions for hyperplasia, but only 1.6% for prostatectomy. Presumably much of this difference was due to deaths in patients not operated on either because they were too ill or for other reasons. This difference between Scotland and London may be accounted for by the fact that, while the Scottish fatality rate for emergency admissions for hyperplasia was 3% (including both operated and unoperated cases), the equivalent figures for the London series was over 9%.

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¹ Graham AG. *Br J Urol* 1977;49:679-82.

² Scottish Home and Health Department. *Scottish hospital in-patient statistics*. Edinburgh: HMSO (annual publication).

³ Ashley JSA, Howlett A, Morris JN. *Lancet* 1971;iii:1308-11.

SIR,—Mr P F Boreham's point (15 March, p 789) is well made. Urology and general surgery have shared the same bed for a long time and will continue to do so for many years to come. In this respect urologists are more than proud of their associate members in the British Association of Urological Surgeons.

Rather than encourage division among those who practise urology in this country, surely we should now seek to strengthen the association to our mutual benefit and, perhaps more importantly, to that of our patients. It would seem therefore important no longer to discuss "an interest" or even "experience" in urology, but now to describe a surgeon with training in urology. In this respect it is important to note that the Royal College of Surgeons has clearly laid down that for appointments requiring both surgical and urological responsibility the training requirements for the applicant should consist of at least two years at senior registrar level in urology. It should be remembered that a urologist is not only an expert at transurethral prostatectomy, but through the development of his subject has increasing contributions to make in the management of urological cancer, stone disease, urinary infection, and paediatric

urology, and in certain centres renal failure, dialysis, and transplantation. By all means let us continue to encourage surgeons to take an interest in urology but not to practise that urology until they have been properly trained in the specialty to the level required by the College of Surgeons. In this way it should be perfectly possible for senior registrars to take on appointments which carry both surgical and urological commitments in a manner of mutual inclusivity.

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SIR,—Many years ago I spent a week in Newcastle upon Tyne watching the work of Wardill, then recognised as the leading authority in Britain on transurethral prostatectomy. Apart from this, however, he had also made some mark by devising a new operation for cleft palate. How many prostatectomists would care to take on a cleft palate today? But then, of course, Wardill was a general surgeon.

Any experienced general surgeon has only to see any operation done a few times to be able to master its technique—in whatever specialty. The why and when might take a little longer. The provincial general surgeons in the 'twenties and 'thirties did not give up removing tonsils, doing hysterectomies, and reducing fractures of the femur because they found them too difficult. They gave them up because the lessening fear of the public to come into hospital at all was making the volume of work impossible to deal with. They therefore handed these over to a younger generation to develop specialties in the provincial hospitals which scarcely existed outside the teaching schools before the 'thirties.

I do not mind the transurethral prostatectomists building their own little empire, but surely they should not do this by denigrating the abilities of the general surgeon. After all, it was a general surgeon in Newcastle who, nearly 40 years ago, showed them how to do it.

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***This correspondence is now closed.—Ed, *BMJ*.

TABLE I—Prostatectomy, Scotland, Hospital fatality by department and operation, 1971-76²

Operation	Urology			General surgery		
	Discharges and deaths (D + D)	Deaths	Percentage deaths/D + D	Discharges and deaths (D + D)	Deaths	Percentage deaths/D + D
Suprapubic transvesical ..	1956	72	3.7	2954	91	3.1
Retropubic ..	1875	34	1.8	1198	19	1.6
Transurethral ..	6116	96	1.6	1641	30	1.8
Not elsewhere classified ..	289	11	3.8	2379	79	3.3
All operations ..	10236	213	2.1	8172	219	2.7

TABLE II—Hyperplasia of prostate: percentage discharges and deaths over age 75 and percentage emergency admissions with fatality percentage—Scotland 1971-73 and 1974-76²

	Urology				General surgery			
	1971-73		1974-1976		1971-1973		1974-1976	
	No	%	No	%	No	%	No	%
Percentage discharges over 75 ..	1612	26.6	1955	28.5	1699	29.4	1560	29.7
Fatality rate over 75 ..	70	4.3	70	3.6	71	4.2	98	6.3
Percentage emergency admissions ..	1553	25.6	1662	24.3	2511	43.5	2306	43.9
Fatality rate for emergency admissions ..	52	3.3	49	2.9	108	4.3	69	3.0
Fatality rate for all admissions ..	128/6058	2.1	130/6849	1.9	164/5768	2.8	119/5256	2.3

Non-fatal disease due to inhalation of nebulised paraquat

SIR,—Drs M George and R B Hedworth-Whitty's article (29 March, p 902) prompts me to report another case of disease apparently due to inhalation of nebulised paraquat.

My patient was born in 1930 and was under my care for follow-up of pulmonary tuberculosis, which had been treated in the 1960s and which remains quiescent. During 1974 he experienced a total of seven episodes of malaise, cough, fever, and sputum. He himself finally discovered the cause of these and he and his wife noticed that they all followed 36-48 hours after he had been working in a local stone quarry. He was then working using a diamond stone-cutting saw which required to be water cooled. Not having water near the saw he carried it in a plastic container from a nearby tap. He later discovered that the container had been dumped over the side of the quarry and had previously contained Gramoxone (paraquat). It seems therefore that the water used to lubricate the wheel was contaminated and when the wheel was cutting a fine spray of water was