region of the wound as being a common source of wound infection. By the time frank pus is discharging the evidence of the haematoma has disappeared. If wounds are carefully looked at daily, evidence of haematoma can be seen early and aspiration or evacuation on removing a skin stitch or two often prevents the development of infection. Antibiotics are effective where there is a blood flow through the tissues but do not reach the centre of a blood clot.

Meticulous haemostasis may be tedious and time consuming but is surely very important in the prophylaxis of surgical wound sepsis.

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Rectal biopsy in the diagnosis of lymphoma

SIR,—I was interested to read the short report by Dr J M Rhodes and others (12 April, p 1043) advocating the early diagnosis of alpha-chain disease by rectal biopsy. The recognition of abnormal lymphoid cells in the rectum does not appear to be confined to patients with pure alpha-chain disease. In a series of 80 patients who presented with non-Hodgkin's lymphoma there was an overall incidence of 24% of cases where probable nodules of tumour were detected in the lamina propria. In a preliminary analysis of the data it was found that by no means all patients were those with advanced disease and in only four of the 18 positive cases was there overt gut disease as a presenting feature. The tissue was processed for immunoperoxidase study rather than immunofluorescence, and in the majority of cases it did not show monoclonal staining. However, the amount and pattern of infiltration was convincing on a morphological basis; and it appears to be a genuine phenomenon that the rectal mucosa may show tumour infiltration in non-Hodgkin's lymphoma, particularly of low-grade malignancy.

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Kidney biopsy

SIR,—We do not disagree with many of the worthy comments (12 April, p 1054) made by your correspondents on our article on kidney biopsy (23 February, p 547). We were not asked to review the subject in depth and we simply described one method which in practice works.

Dr M C Bateson's dogmatic advice—to follow the procedure recommended by the manufacturers—is, however, puzzling. The technique we described is one of the two alternatives given in the instruction leaflet, which does not refer specifically to the kidney but which says that it may be the preferred one for breast biopsy. Presumably he is referring to the method the leaflet advocates for "usual biopsy procedures," in which, after the needle has been inserted with the obturator retracted so that the specimen notch is within the tissue, the cannula is retracted and advanced with the obturator held fixed. This might be relevant to liver biopsy but is not applicable to the kidney. The difference is that the surface of the kidney has to be located by the biopsy needle and if his suggestion is

followed the specimen obtained will probably be perinephric fat. The Menghini needle is unsuitable for the kidney because the weight of its attached saline-containing syringe must increase the risk of laceration of the kidney. We do not have enough information to comment about the relative economics and safety of disposable versus reusable needles but, on the page following Dr Bateson's letter, Dr C E Blogg (p 1055) writes strongly in favour of disposable ones for the different but comparable technique of lumbar puncture. In any case we did say that the reusable Vim-Silverman needle was equally suitable.

Advising the measurement of bleeding time as a screening test, Dr R G Hughes refers to a paper published in 1940, which was many years before percutaneous kidney biopsy was introduced. We have never used the test for this purpose ourselves, and in several hundred biopsies carried out or supervised by one of us (PS) only one patient had a bleed large enough to require blood transfusion, and none has required surgical intervention.

While we fully agree with Dr J R T Gabriel's implication that considerable practice (under supervision) is necessary before one becomes proficient, we are less certain than he is about the need to do "at least two biopsies each month" to maintain competence. In this respect renal biopsy is not all that different from riding a bicycle.

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Organ donation and the GP record card

SIR,—The recent request by ophthalmologists for more people to donate their corneas, allied to the ongoing discussion about the lack of enough kidneys for the transplant surgeons has highlighted for me an important omission in the present GP record card, and one which does not figure largely in discussions about how the card might be improved. Would it not be a good idea if there were a small but prominent marked space on the front of the card where it could be indicated if the patient has made any organ bequests? Quick action after death is needed, and I wonder how many organs are lost for transplantation because the existence of a bequest is not realised soon enough even by the doctor in attendance. The relevant legal documents are doubtless tucked away somewhere inside the folder; but they may well be overlooked, particularly if the death occurs suddenly or if it is not the patient's own doctor who is called. This situation would be unlikely to occur if there were an appropriate indicator on the outside of the record card. Furthermore, knowledge by the public that such a space is standard on every record card might encourage people to bequeath organs who at present do not do so simply because the matter goes by default.

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Development surveillance at 8 months

SIR,—In Dr H B Valman's article on developmental surveillance at 8 months (12 April, p 1049) the section devoted to examination of vision contains information which I consider to be misleading.

A description of the cover test for the detection of squint is given. It is stated that one eye is covered with a card which is gradually moved away sideways and that if the eye which is being uncovered moves there is a squint. If this is meant to imply that a manifest squint is necessarily present it is incorrect. For even in the absence of a manifest squint an eye may deviate when it is covered and will move to take up fixation when the cover is removed. Such behaviour indicates the presence of a latent squint (heterophoria) and is common and not necessarily of significance. If the presence of a manifest squint is being sought the child is made to fixate an object and each eye is covered in turn. It is to the eye which is not being covered that attention should be given. If this eye has to move to take up fixation when the other is covered then it must have been squinting before. If neither eye moves when the other is covered a manifest squint is almost certainly not present. One may then go on to examine the movements of the eye which is being uncovered to determine if a latent squint is present.

The article then goes on to say that if a squint is seen or suspected any time after 6 months the infant should be seen by an ophthalmologist. This gives the impression, possibly unintended, that a squint seen before this age may safely be ignored. It is true that during the period when the binocular reflexes are being established a squint may sometimes be seen. Such a squint is usually short lasting and the eyes will rapidly become straight again. A permanent squint should never be ignored whatever the age of the infant. It should not be forgotten that a squint is sometimes the result of poor vision due to organic disease in an eye or affecting the visual pathway. A squint may also result from damage to one of the oculomotor nerves by active disease. Such conditions, although uncommon, must be excluded at the earliest opportunity. Delay in diagnosis may even prove to be fatal—for example, if a retinoblastoma is present.

I must therefore urge that any infant with a squint, however young, be referred immediately to an ophthalmologist for examination, including inspection of the fundi after mydriasis.

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* * * The impression that a squint seen before the age of 6 months may safely be ignored was unfortunately given because the article dealing with development surveillance at 6 weeks was in the journal of 5 April, which has not appeared owing to the printing strike. This article will, however, be published later.
—ED, *BMJ*.

SIR,—Whereas one has much enjoyed the series by Dr H B Valman on paediatric problems, I fear that his method of hearing testing at 8 months cannot go undiscussed (12 April, p 1051).

The method he describes is in essence the Dr Mary Sheridan technique, and although this can give useful information I feel that methods of testing have moved on since then. To test infants' hearing reliably the baby must be sitting firmly. It is necessary to know the approximate level of intensity of sound used; to pass free-field hearing as normal one expects

a response to sound of 35-40 dB free field; hence toilet paper and bells are out, as they emit 60 dB on quiet use. It is necessary to cover the frequency range, and therefore to use high-frequency sounds (Manchester rattle or Nuffield), low frequency sounds (a metal spoon on a cup rim), a voice producing high-frequency sounds ("ss") or low sounds ("oo"), and speech at 35-40 dB using a minimal voice. This form of testing combined gives us the distraction test, needing one person on the "front" to distract and plateau the babe's attention, and one "behind" to give the stimuli. If the baby fails the test and does not respond at a level of around 35-40 dB, then the sounds can be raised and an objective assessment made of the level necessary for response. The idea of distraction with one hand and putting in sounds with the other, especially if it is a cup and spoon, belies belief. The distraction test as described can be used for babies of 7-18 months, and is a very useful method of testing when babies have missed being screened until late.

Contrary to Dr Valman's opinion that the commonest reason for a child failing is lack of interest, I would say the commonest reason is a mild secretory otitis media. After this come immaturity resulting in fixing on the distractor or lack of attention to sound, and social deprivation and lack of stimulation making sound less meaningful to the child—and, of course, from this test you hope to pick up your profoundly deaf child in infancy, and hopefully your partially deaf child who has a high-frequency loss but normal hearing in the low frequencies.

This testing is now done in many parts of the country with a clinical medical officer and a health visitor, or two health visitors. I think it is important if a baby fails that he should be examined by a doctor. Mild upper respiratory troubles often may be quite silent as far as the mother is concerned and give rise to hearing losses. If these are not found in the early months and years you have all the attendant problems of glue ear, lack of attention to sound, delayed language, and lack of learning by the time the child approaches school age.

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* * We sent this letter to Dr Valman, whose reply is printed below.—Ed, *BMJ*.

SIR,—Dr Gumpel's letter provides some additional information which complements my brief description of hearing tests. To ensure that the infant had moved his head to the test sound and not by chance it is essential that some form of distraction is used. This can be provided by a health visitor facing the child or by a loud sound (a bell or toilet paper) produced by the examiner. The latter method has the advantage that it can be performed by those unfortunate health visitors, family doctors, and consultant paediatricians who do not have a "distracting" health visitor constantly available. I failed to mention that the most effective form of distraction is provided by an older sibling, especially a toddler. To avoid disrupting the test it is best to advise that he should be left at home.

I had assumed, apparently in error, that if an infant did not respond to the test sounds he would be examined with an auroscope to detect wax or otitis media. I agree with Dr Gumpel

that if an infant fails to respond to test sounds he should be seen by a doctor, who should examine the ears.

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Chemoprophylaxis for contacts of *Haemophilus influenzae* meningitis

SIR,—Dr Mary P Glode and others (29 March, p 899) recently published an account of secondary cases of *Haemophilus influenzae* meningitis. They followed up 126 consecutive cases presenting over a three-year period at Boston Children's Hospital. Four secondary cases were identified in 171 household contacts aged less than 5 years old occurring within a month of the index case. They concluded that this confirmed the opinion of Ward *et al*¹ about giving chemoprophylaxis to children under 5 from the households of cases of *haemophilus* meningitis.

Both of these papers report experience in the United States, where *H influenzae* is the commonest cause of bacterial meningitis.¹ This is because of an absolute increase in the number of cases of meningitis due to this organism in recent years.^{2,3}

In Great Britain the meningococcus is the commonest cause of bacterial meningitis, even in children.⁴ We have recently reviewed all cases of bacterial meningitis admitted to East Birmingham Hospital from 1968 to 1977 and also the discharge figures for the entire Birmingham Area Health Authority from 1969 to 1978. *Neisseria meningitidis* caused over twice as many cases of meningitis as *H influenzae* and was the commonest cause of meningitis in children under the age of 5. The annual fluctuation of notifications of meningococcal meningitis was significant at the $p < 0.001$ level (see accompanying table). Three patients with bacterial meningitis at East Birmingham Hospital had a history of contact with meningitis and two of these had meningococcal meningitis. The third case had a sterile cerebrospinal fluid and blood culture but there was a petechial rash suggesting meningococcaemia.

Epidemics of meningococcal disease have recently been reported from England⁵ and from the United States.⁶ The mortality in these epidemics was 19% and 31% respectively.

Chemoprophylaxis for contacts of meningococcal meningitis is thus based on sound evidence of major epidemics and fluctuations in annual incidence, not on sporadic secondary cases, a picture which is endorsed by our results. It is entirely inappropriate to compare this with the experience reported by Dr Glode and her colleagues.

Even if we allow for this, the case for chemoprophylaxis for child contacts of *H influenzae* meningitis is not strong. Turk⁷ reported a detailed study on contacts of infections due to *haemophilus* type B. All of 11 families with three or more children had at

least one member with raised titres of antibody to *H influenzae* at the time of the index infection, suggesting that the organism had been in the family for some weeks. Nasal carriage of the organism persisted for up to six months, not only in family contacts but also in the index cases following treatment. It is therefore possible that children under 5 would still be at risk after a course of chemoprophylaxis and that prophylaxis for the whole family is required, a much larger undertaking.

Until conclusive evidence of the benefit of such chemoprophylaxis is obtained it seems unreasonable to recommend this policy with its considerable risk of inducing resistance to useful antibiotics. Such evidence will be difficult to obtain in this country since, as our figures show, the number of cases is relatively small.

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¹ Ward JI, Fraser DW, Baraff LJ, Plikaytis BD. *N Engl J Med* 1979;301:122-56.

² Fraser DW, Henke CE, Feldman RA. *J Infect Dis* 1973;128:300-7.

³ Haggerty RJ, Ziai M. *Adv Paediatr* 1964;13:129-81.

⁴ Goldacre MJ. *Lancet* 1976;i:28-31.

⁵ Easton DM, Estcourt PG, Brimblecombe FSW, Burgess W, Hass L, Kurtz JB. *Br Med J* 1974;ii:507-9.

⁶ Foster MT, Sanders E, Ginter M. *Am J Epidemiol* 1971;93:346-53.

⁷ Turk DC. *J Hygiene* 1975;75:315-32.

Guidelines for research in children

SIR,—May I take this opportunity of congratulating the British Paediatric Association for its initiative in producing guidelines to aid ethical committees considering research projects involving children (26 January, p 229). For some time issues concerning this matter have been raised with our association—in particular, the responsibilities and role of parents. We have considered this matter at some length and wish to state that we accept the association's main premises.

We should like to draw readers attention to the aspects concerning parental permission and co-operation. Staff do experience difficulties in explaining research procedures. Ways must be found to overcome this fundamental difficulty in order that a parent may fully understand before agreeing to the procedures on behalf of their child. Clearer guidelines are required on the means of ensuring that consent is freely given and that staff explain as fully as possible without raising undue anxiety or confusion. Parents often need more time to talk informally with someone informed but not directly involved in the project.

Signed, witnessed consent forms, as an extension of spoken explanations but not a substitute for them, would safeguard the parents' access to information regarding

Annual hospital discharges for meningitis due to *N meningitidis* and *H influenzae* in Birmingham

Causative organism	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	Total cases
<i>N meningitidis</i>	25	40	23	38	59	42	20	21	17	11	296
<i>H influenzae</i>	21	15	9	18	12	6	11	10	17	10	129

The annual fluctuation for meningococcal cases is significant (χ^2 with 9 df = 65.3, $p < 0.001$); the fluctuation for *haemophilus* cases is not (χ^2 with 9 df = 15.26, $p > 0.05$).