lasting deviation from the previous dramatic improvement in the infant mortality figures.

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Development surveillance at 8 months

SIR,—The importance of developmental surveillance is so often overlooked that Dr H B Valman's article (12 April, p 1049) is particularly valuable at this time. Testing hearing involves a good deal of personal preference and it has been our experience that it is in this particular field that many, perhaps an increasing number, of critical mistakes are being made. For this reason we would like to elaborate on some of the points made by Dr Valman.

(1) The noise of the spoon against the cup can produce such a wide range of sound intensity that it should be strictly defined. Stroking of the rim of a cup at 3 ft from the ears at meatus level gives an acceptable screening level, while tapping may give falsely reassuring responses. This produces a sound which includes the low frequencies.

(2) A good idea of the presence of high-tone hearing loss can be obtained from the Manchester rattle at 90 cm (3 ft) or the Nuffield rattle at 23-30 cm (9-12 in) held at the level of the meatus as they produce a high-pitched sound of around 8 KHz frequency.

(3) When speech sounds are used these should really be voiced and not whispered as the latter contain only high tones. When high-tone hearing is being tested ss-ss at 90 cm and ear level are best.

(4) We have generally given up using crinkled paper and bells for screening as we find it very difficult to keep down to the proper sound level and the frequencies produced are both mixed and variable.

(5) We have seen so many mistakes when babies are tested by a single person from the back that we urge the formation of two-person teams, where one member can both visually distract and observe. We realise that this cannot be possible in all circumstances but the lone tester should have no illusion regarding the hazards of this technique.

It is our awareness of a growing number of overlooked cases of deafness that has suggested these rather precise criteria and we hope that our remarks will add to the value of Dr Valman's article.

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Convulsions in the older infant

SIR,—In the paper by Dr H B Valman on convulsions in the older infant (26 April, p 1113) I was especially interested in the diagram he included to indicate the position in which a child should be placed during fits. The reason for this posture—vomiting with aspiration—is included in the text.

I have always believed that the safest position during vomiting is on hands and knees rather than one of the more usually described left lateral or prone positions. This is not practical for most adults during recovery from general anaesthesia. Very small children

may, however, be placed in this position with one hand under the chest supporting the trunk and the other holding the head or clearing the airway. Larger children may be placed prone across a pillow with one arm and the ipsilateral leg flexed and the head supported half flexed and rotated to the same side. Should vomiting occur that position is very safe, or both legs and arms may be flexed and the head supported in an approximate and stable knee-elbow position.

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Recurrent abdominal pain in childhood

SIR,—In your leading article "Recurrent abdominal pain in childhood" (26 April, p 1096) you make no reference to childhood migraine, which I believe to be synonymous with the periodic syndrome and possibly with cyclical vomiting.

I have always been impressed by the characteristic pattern which is seen in children of families with a positive history of migraine. These children, slightly more often boys than girls, present with abdominal pain. When one takes the history the presentation is quite different from that of organic causes. Usually the first symptom is food refusal and it is noted that the child looks pale and unwell. On being asked what is wrong he or she volunteers the information that "I have a pain in my tummy." There may be vomiting, particularly in older children; and a specific question about the existence of headache will often produce a positive response. In time many of these children, particularly the girls, will develop typical migraine.

Because of the lack of objective markers this is a difficult subject to study. I would, however, be interested to know if other people believe in the entity of childhood migraine.

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SIR,—Your leading article (26 April, p 1096) on recurrent abdominal pain in childhood raises several interesting questions. Your criticisms of the inadequate scientific basis of certain claims regarding dietary factors in the aetiology of this condition are justified, but it is surprising that you should accept a lower standard of evidence as regards possible emotional factors in either the child or the family background. For example, the effectiveness of psychological methods of treatment cannot in itself be taken as evidence of an underlying psychological cause. As you yourself rightly state with regard to dietary forms of treatment, such a retrospective argument is inadmissible, in view of the known effect of the doctor's interest and enthusiasm in enhancing the value of his treatment, and the extreme difficulty in carrying out properly controlled trials of psychological forms of treatment.

What is not clear from your editorial is how the diagnosis of emotional disturbance is to be made, apart from the fact that the patient presents with a symptom for which a psychological cause is frequently presupposed. The absence of evidence of organic disease cannot,

in itself, be taken as evidence of an emotional basis for the disorder, since a negative finding cannot logically be used to infer a positive conclusion. To claim that the negative finding merely stimulates the search for emotional factors and is not direct evidence for them does not alter the logical position, since whenever emotional factors are sought in anybody they can invariably be found. Your suggestion that school reports may highlight relevant factors illustrates the speculative and subjective nature of much of the evidence. Teachers' reports are often notoriously lacking in objectivity, and such a report is necessarily a description not of the child but of the way in which the child and teacher interact, depending for interpretation on the teacher's own preconceptions. Even if we leave aside the serious questions of confidentiality which arise for both teachers and doctors, that children should be medically assessed on the basis of school information smacks of social control. All too often reports by such third parties get enshrined in the records and gather moss, so that anyone coming to the case may form the impression that it has already been fully evaluated, when all that has happened is that a family has been labelled, possibly quite without justification, and all their behaviour has been interpreted subsequently in the light of the label. I have recently had direct personal experience of such a case, and would advise doctors to be extremely cautious about the use to which such reports from third parties are put.

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Female sterilisation—no more tubal coagulation

SIR,—For more than 20 years a large proportion of my time has been taken in giving advice about birth control. Through the years there have always been a minority of patients opting for female sterilisation, more since laparoscopic sterilisation became available. The advantages of this method to the busy mother whose family was complete are obvious, with the quicker recovery and shorter hospital stay.

In the last three years more and more gynaecologists have been using plastic and silicone clips and rings. In your leading article (12 April, p 1037) you quote similar pregnancy rates. In my practice the only failures have been when tubes have been occluded by clips. I would like to put in a plea for still using laparoscopic sterilisation with cautery in women who are unlikely to change their mind. In this category I would consider particularly women who are happily married and whose family are now adolescent. An added factor is that the women may be unsuitable for having more children. In these patients the situation can be even more difficult because they feel quite unable to accept a termination of pregnancy should contraception fail. Both husband and wife should understand the procedure, and in particular make their decision knowing that it is irreversible and that repair of the tubes does not often lead to a successful pregnancy. The type of sterilisation should be tailored to the request of the individual patient.

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