Antivenom should be used only by medical staff who are able to recognise and treat serum reactions. I disagree with the routine use of "high-dosage cortisone" before antivenom, advocated by Mr Brossy.⁸ Early reactions occur in less than a quarter of the patients and so it seems unreasonable to expose all to the general dangers of corticosteroids⁹ and possibly to increased venom toxicity.¹⁰ Corticosteroids are not always successful in preventing early serum reactions, but these reactions can be safely and effectively treated with adrenaline, 0.5 ml of 0.1% solution by subcutaneous injection.² The incidence of reactions due to anticomplementary activity may be reduced by diluting the antivenom and by giving it by slow intravenous infusion.¹¹

In reply to Mr M J Gilkes, the evidence that venom from the spitting cobra frequently causes corneal ulceration and may be absorbed to cause hypopyon and anterior uveitis is based on my own experience of 11 cases, nine of which have been reported, and on published observations on patients and animals which have been reviewed.¹²⁻¹³ Urgent, generous irrigation with water is the best first aid, as with other irritant chemicals. In the hospital or dispensary the cornea should be examined daily for at least three days, by fluorescein staining or preferably slit lamp, to detect ulceration, which occurred in five of my patients. The greatest danger is infection, so it seems rational to treat the eye locally with an antimicrobial and to close it with a pad. Despite what he writes in his letter, Mr Gilkes's paper¹⁴ records that he *did* exactly what I have recommended! I agree with him that there is inadequate evidence to justify the use of topical antivenom, although this deserves to be properly investigated.

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¹ Warrell, D A, *et al*, *American Journal of Tropical Medicine and Hygiene*, 1976, **25**, 517.

² Reid, H A, *Tropical Doctor*, 1972, **2**, 159.

³ Russell, F E, *et al*, *Journal of the American Medical Association*, 1975, **233**, 341.

⁴ Fairley, N H, *Medical Journal of Australia*, 1929, **1**, 377.

⁵ Christensen, P A, *South African Medical Journal*, 1969, **43**, 1253.

⁶ Warrell, D A, *et al*, *British Medical Journal*, 1975, **4**, 697.

⁷ Theakston, R D G, and Reid, H A, *Lancet*, 1976, **2**, 121.

⁸ Brossy, J, *South African Medical Journal*, 1977, **51**, 390.

⁹ W T, *Toxicol*, 1977, **15**, 473.

¹⁰ Jerushalmi, Z, *et al*, *Coagulation*, 1970, **3**, 267.

¹¹ Sutherland, S K, *Medical Journal of Australia*, 1977, **1**, 613.

¹² Warrell, D A, and Ormerod, L D, *American Journal of Tropical Medicine and Hygiene*, 1976, **25**, 525.

¹³ Payne, T, and Warrell, D A, *Archives of Ophthalmology*, 1976, **94**, 1803.

¹⁴ Gilkes, M J, *British Journal of Ophthalmology*, 1959, **43**, 638.

Sexual pressures on children

SIR,—Over the last year there has been increasing public awareness of sexual pressures on children, with all the consequent health damage to the individuals involved.

We wish to draw the attention of the profession both to the Government funding of organisations which promote juvenile sex and to the environmental health hazards of the behavioural attitudes promoted and encouraged by much of the contents of teenage magazines, many with massive circulations, which reinforce the callous advice of these official bodies. It is our experience that the long-term effects of these influences undermine

the role of many responsible parents and, by encouraging irresponsibility in others, leave many children unprotected against sexual exploitation by adults.

As examples of "official" organisations undermining the family we will briefly mention some of the promotional/educational activities of the Family Planning Association (which handed over almost all its clinics to the NHS in 1974) and of the Family Planning Information Service, together with some of the controversial educational and clinic activities of the Brook Advisory Centres.

The Family Planning Association is a charity which is in receipt of large sums of public money and which runs its own contraceptive business, Family Planning Sales Ltd. It publishes and promotes a large quantity of aggressively permissive literature for young people—for example, "Learning to Live with Sex," published in 1972 for children of 13 years upwards. This booklet, which is claimed by the FPA to have a very large circulation, has the following emphases: (1) it describes sexual intercourse in terms of "boys and girls," which implies an acceptable code of behaviour; (2) there are six full pages on contraceptive methods; (3) there are 10 lines on "responsibility," which is equated almost entirely with the use of contraceptives. (4) there is no section on marriage. (5) It does not mention the positive health and social advantages of self-control, nor does it mention the failure rates of contraceptives, the association of cancer of the cervix with early adolescent intercourse, and the cruel consequences of abortion for many girls who have their first pregnancies terminated.

The Family Planning Information Service is Government sponsored and funded and administered by the Health Education Council and the Family Planning Association. It claims to have sent out millions of copies of a leaflet, "Straight Facts about Sex and Birth Control." This leaflet describes sexual intercourse in terms of a boy-girl partnership, it advertises the FPA mail order business, and tells of special places where one can get contraceptives where "older relatives and neighbours will not be present."

The Brook Advisory Centres specialise in providing contraceptives and (more recently) abortions for young girls and believe that adolescent sexual intercourse is acceptable provided that contraceptives are used. It has long been their policy not necessarily to inform parents of their adolescent children's difficulties. Recently the Department of Health and Social Security has provided £21 000 a year for three years towards their headquarters' administrative costs.

However, perhaps the most damaging influence on young adolescents' sexual health comes from the teenage magazines. Much of the advice given by some of the journalists employed by these periodicals can only be described as "sick." The seriousness of the damage to children's health caused by these magazines was clearly recognised in April, when the National Council of Women in conference assembled, perturbed by the nature of the material appearing in magazines for teenage girls, called for tighter implementation of the Children and Young Persons (Harmful Publications) Act 1955 and urged the Home Office and the Williams Committee on Obscenity to investigate the resultant effects on the physical, emotional, and psychological health of young teenage girls.

In view of these physical and emotional dangers it is of the utmost importance that parents should be aware of and defend their children against such pressures. Here again the Department of Health and Social Security further undermined parental influence when on 6 May 1974 it issued the now infamous memorandum, Guidance on Family Planning Services, No 32, which states that "the Medical

Defence Union have advised that the parents of a child of *whatever age* should not be contacted by any staff without his or her permission even though as a matter of clinical judgment the refusal of permission to involve parents may affect the nature of the advice given to the child." As a direct result of this document planning guidelines have now been issued to health authorities drawing attention to the "need" to provide special family planning services for the young.

We fear that in addition to undermining our professional standing with parents, who will inevitably learn of our complicity in their deception, these clinics will follow the recognised Swedish pattern—namely, an increase in juvenile sexual activity with a consequent rise in venereal diseases, illegitimate pregnancies, and abortions among young adolescents.

Not only should our profession protect its own integrity and resist these unhealthy trends—and in doing so protect the health of vulnerable teenagers—but also the time has come for the British Medical Association to question publicly the nature of the pressure groups which, having so devastatingly eroded our ethics and authority in health matters, have already seriously undermined our capacity to care adequately for the defenceless.

S E ELLISON

Chairman,

AMBROSE KING

JOHN PEEL

BRIAN WINDEYER

Sponsors,

The Responsible Society,
and 147 other members of
the medical profession

London W1

Maternal nutrition and infant birth weight

SIR,—I read with interest the article by Dr J R Sibert and others entitled "Maternal and fetal nutrition in south India" (10 June, p 1517). I do not disagree with the authors' suggestion that "an adequate maternal diet is necessary for adequate fetal growth," but I do not feel that their data show this.

Firstly, the food intake of the non-paying (poorer) patients studied is merely described as "inadequate" and no precise information about maternal nutrition either before or during pregnancy is provided, nor are we told the maternal weight of either group, nor their weight gain during pregnancy.

Secondly, although the well-known association between maternal height and infant birth weight^{1,2} has been confirmed by the authors in their total study group, they appear to have ignored the fact that the non-paying mothers were significantly shorter than those who paid for their care and that the two groups studied were therefore not comparable for this most important characteristic.

Thirdly, the observation that the maternal skinfold thickness in the non-paying group was less than that of the paying patients just before delivery is not necessarily solely due to differences in maternal nutrition during pregnancy but quite possibly reflects prolonged nutritional deprivation over many years (as suggested by the difference in the heights of the two groups). This is important, as maternal prepregnancy weight displays a highly significant positive correlation with infant birth weight^{2,3} which is independent of the effect of maternal weight gain during pregnancy.³

Finally, the authors do not mention whether the two groups studied were matched for maternal parity and infant sex, both of which are known to have a major effect on infant birth weight.

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¹ Thomson, A M, Billewicz, W Z, and Hytten, F E, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1968, 75, 903.

² Moghissi, K S, Churchill, J A, and Kurrie, D, *American Journal of Obstetrics and Gynecology*, 1975, 123, 398.

³ Hytten, F E, and Leitch, I, in *The Physiology of Human Pregnancy*, 2nd edn, p 318. Oxford, Blackwell Scientific, 1971.

Children who cannot read

SIR,—Regarding your leading article on this subject (1 July, p 3), I would like to make two points.

Firstly, one omission which I feel should be rectified is the fairly recent awareness of early hearing problems on later learning. Variable hearing loss during preschool years is so common and if not diagnosed and treated there is almost always delay in language and therefore speech, plus or minus inattention to sound and lack of listening. All these factors are important to the later more academic learning, reading and numeracy in particular.

Secondly, certainly the last sentence of your leader was the most relevant, although in my view almost understated. The identification of learning difficulties in children far outweighs the facility to do anything about them.

Examination of children by the school doctor, who evaluates them both physically and developmentally in detail at 5 years, can and usually does identify problems both general and specific. Any child showing these problems can then be referred to the educational psychologist, who at most will visit a primary school twice in one term, but, even if asked for, this facility will not be available until 6 or 7 years of age. Meanwhile the child will have to be accommodated within the infant class of 30-35 children, often with a young, very inexperienced teacher, and as they will be uncontrollable in that class they will spend a large portion of the time in the corridors or in someone's office, and this will go on for 2+ years.

In every batch of 5-year-olds I have tested two to three are in this category and stand out as socially deprived, plus or minus hyperactivity, plus or minus in need of nurturing, and suggest problems of attainment in abilities/language/visual spatial relationships. Even when these children with problems are seen by the educational psychologist at 7 years the recommendation is usually for remedial help within the school the child is attending, and this means help with someone hearing them read in some cases but often not remedial teaching. Then if there is no improvement by 8-9 years they may be seen again by the educational psychologist and a special class be suggested outside the school they are attending, for remedial reading for some portion of three days a week. Hence, although the problems were identified at age 5, there has been minimal help until the latter years of primary school.

Certainly in my view the problems are

identified, but help is given too little and too late.

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SIR,—Your leading article on this subject (1 July, p 3) rightly emphasises that identification is usually easier than help. We agree that a diagnosis of "dyslexia" has shortcomings. It was a useful rallying point in drawing attention to a genuine learning difficulty which is probably biological in origin and not the fault of the child or its parents. It is a disadvantage when teachers assume that it cannot be overcome and educationists use semantic argument as an excuse for doing nothing.

"Specific reading retardation" suggests only half the truth. These children (whichever diagnostic term is used) have even greater difficulty in learning to spell. Writing a sentence is torture to the learner, who has to search for the spelling of every word. When great effort produces mistakes frustration blocks his progress. Without reasonable fluency in writing a pupil cannot begin to cope with the secondary school curriculum.

It is true that remedial teaching methods being used for reading-retarded children vary widely. The fact that general reading retardates respond better in these circumstances than the specific reading retardates surely indicates a need to investigate the remedial measures. Some specific reading retardates are remarkably successful in overcoming their difficulties. What are the reasons for their success? To hypothesise that success is solely due to a teacher's enthusiasm and skill in motivating the child is not only unscientific, it undervalues the teacher's intellectual skill.

The only solution to this problem is evaluation on a large scale of remedial methods, counselling, and general educational management. It will take time, but it is the only way of differentiating the good from the bad among what are at present merely anecdotal claims. It will take money, but it will be more than compensated for by improved achievement and better emotional and social adjustment for the children and their families. This evaluation should be set up by the Department of Education and Science in collaboration with the Department of Health and Social Security.

MARGARET HEATH
MAUD HEATH

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Thyroid extract

SIR,—In 1960, when I was chairman of the International Thyroid Conference in London, a subcommittee under my chairmanship unanimously recommended that thyroid extract should no longer be used. I therefore support wholeheartedly the letter from Dr W van't Hoff and others (15 July, p 200). Yet the fact remains that in many countries thyroxine is still, after 18 years, unobtainable. Why?

RAYMOND GREENE

London W1

SIR, I refer to the suggestion made by Dr W van't Hoff (15 July, p 200) that Thyroid

extract (Thyroid, BP) should be removed from the *British Pharmacopoeia*.

It will be of interest to your correspondents to know that the British Pharmacopoeia Commission has recommended that Thyroid and its preparations be omitted from the next edition of the *British Pharmacopoeia*, which is to be published in 1980.

C A JOHNSON
Secretary and Scientific
Director,
British Pharmacopoeia
Commission

London W1

Family health services and vital statistics

SIR,—With reference to the letter of mine which you kindly published (1 July, p 51) on family health services, I am informed that the recent figures from Singapore were not for publication and I ascribed these figures to the wrong author. I have been asked to withdraw these statements with apologies. The fact remains that the work in Singapore is excellent and should be much more widely studied.

CICELY D WILLIAMS

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Investigating stroke

SIR,—As your leading article (10 June, p 1503) indicates, the results of the study by Weisberg and Nice¹ are truly alarming. The incidence of potentially treatable neurosurgical conditions presenting as seemingly "innocent" strokes in their series is as follows:

Transient ischaemic attacks	2/20 patients = 10 %
"Stroke-in-evolution" (evolving up to 3 days)	13/30 patients = 43 %
Stroke completed in less than 2 hours	9/60 patients = 15 %

These figures compare unfavourably with previous estimates for such a diagnostic error, which range from less than 1% to 3.3%.²⁻⁶ Pearce⁷ estimates that 10-15% of cerebral tumours are responsible for an acute stroke syndrome but does not indicate what percentage of strokes are caused by tumours. Surely clinical follow-up in the outpatient department and by general practitioners would have uncovered a diagnostic error of the magnitude reported by Weisberg and Nice. It is likely that their results were influenced by the selection of patients with a high index of suspicion of a non-vascular aetiology—a possibility which the authors admit. Despite this confession, the authors do not tell us exactly what selection criteria were used and merely describe their choice as "130 consecutive patients."

It is essential for the general physician to be able to delineate criteria for the referral of stroke patients for computerised axial tomography (CAT scanning). In a district general hospital this investigation can be obtained only by the intervention of a neurologist or neurosurgeon. Logically, selection criteria should include relative youth, fitness for neurosurgery, and absence of significant hypertension or coronary artery disease, unless, of course, there is evidence of raised intracranial pressure. The temporal evolution of a stroke would seem to be a useful pointer to the underlying pathology, but if a supposed