Developmental screening

SIR,—It was pleasant to see my name included in the reference list of Dr D J G Bain's paper on developmental screening by general practitioners (6 August, p 363). I would, however, be even happier if I had been quoted correctly. I did not question the *concept* of routine surveillance. Indeed, in the summary of my paper¹ I said: "It is highly desirable that every infant and young child should be examined at intervals to identify remedial defects." What I did question was the value of some of the tests carried out: "The real issue is not whether all developmental paediatric examinations are essential, but which part of the examination is." For example, I stressed the vital importance of examining *every infant* at about the age of 7 months for squint and hearing defects. I was therefore upset that this had been done for less than two-thirds of the children examined by the GPs in Dr Bain's series. I also made the point that developmental surveillance should be part of general practice.

Let me therefore reassure those who are interested that I am in agreement with what Dr Bain is saying. He may not have many friends in this debate. It would be folly for him to lose this one.

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¹ Carne, S, *Update*, 1976, 12, 535.

Vision screening in preschool children

SIR,—It is a matter of some concern that the survey carried out by Dr D J G Bain (6 August, p 363) showed that general practitioners holding developmental screening clinics omitted a test for visual acuity in 30% of the 4½-year-old children, not to mention omitting a specific test for squint in 70%. It is a reasonable presumption that general practitioners who do not hold developmental screening clinics would not be as active in this way as those who do.

The Court Committee reported that in an investigation in the Newcastle area 92% of visual defects discovered at school entry had passed unnoticed up to the time of this examination.¹ However, without further evidence of the prevalence of defects among those not tested and the severity of the defects undiscovered the case is not made for universal screening before school entry.

Visual defects arising just before school entry are rare. The majority are present throughout the preschool years. In many this is the most favourable period in which to treat defects. For this reason, though screening is time-consuming and the results difficult to interpret, I believe that the aim should be to discover serious defects in this age group at the earliest possible moment so that those which are treatable are treated and those which may handicap general development are known about. This does not involve testing every child. If attention is concentrated on specific groups, in addition to those with signs and symptoms, few of importance will escape. Minor defects of acuity are not of importance and it is doubtful if universal screening is worth the time spent.

In otherwise normal children these groups are the offspring of parents who had a defect arising in infancy, the siblings of children known to have a defect arising before school entry, and twins. In addition, the

retarded, the brain-damaged, the deaf, and those with developmental or congenital disorders of whatever nature also need to have a definitive statement about their eyesight. If this is difficult to assess ophthalmological and orthoptic opinion should be the rule in all these children. Whether this is the responsibility of the paediatrician, the general practitioner, or the community specialists in child health is debatable, but the debate should not be an excuse for omitting tests in these groups, nor should the quest for universal screening belittle the process and lead to the abandonment of these useful priorities.

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¹ Committee on Child Health Services, *Fit for the Future*. London, HMSO, 1976.

Immersion and drowning in children

SIR,—Referring to your leading article (16 July, p 146), which advocated central body rewarming (CBRW) using hot moist air for immersion hypothermia, the Royal National Lifeboat Institution, RAF search and rescue branch, and the Royal Navy, which jointly have the widest experience of immersion hypothermia and its treatment, have been studying for over two years the possible medical value and operational feasibility of using the soda lime/CO₂ CBRW technique. Consideration of the thermal dynamics of rewarming via the airway and the physiology of respiratory air conditioning justifies this,¹⁻⁴ but the work is not yet complete and none of these rescue authorities have taken any positive decisions on the use of CBRW.

One value of CBRW would be in countering respiratory heat (and moisture) loss, which can equal or exceed 10-15% of total metabolic heat production, particularly in deeply hypothermic casualties at or below the level of shivering (core temperatures below 32-33°C), whose heat production capabilities are very low. Any excess of inspired moist heat above respiratory loss would be "surplus," and although this could amount to several kcal/h, the total heat increment in CBRW is small compared with the amount which would be needed to restore normal body temperature in a deeply hypothermic casualty while in the charge of a rescue unit. However, if CBRW, with other recognised treatment, helped to prevent further depression of core temperature, including the "after-drop" during rewarming, and initiated a slow rise, even of only 1-2°C, this would be valuable in progressively reducing the risk of ventricular fibrillation during the stressful period of casualty evacuation and increasing the chances of survival.

The precise pathways of the heat "surplus" are not yet fully understood⁵⁻⁷ and it has still to be determined whether there is a selective rewarming of the hypothalamus, myocardium, mediastinum, etc and what the effect of such heating would be on respiration, heat production, and the core temperature.

Soda lime/CO₂ equipment can give initial wet heat temperatures of 80-100°C, and I myself twice sustained mouth burns by accidental inspiration of hot wet air at 60+°C during early work with uncontrolled equipment.⁵ Upper airway tolerance of wet heat is variable. Most people find 40-45°C tolerable, even pleasant, but some find 45°C "getting hot"; at over 50°C it rapidly becomes un-

pleasant and intolerable, and prolonged breathing at this level would undoubtedly constitute risk of damage to the upper airway. A safe and acceptable level of heat at the face mask can be obtained only by inclusion of a fail-safe device to dilute and control the hot wet air flow during the initial heat surge period. Transfer of uncontrolled wet heat to unconscious casualties would be quite unacceptable.

A medically supervised evaluation programme under rescue service (coastal/sea) conditions is scheduled to start later this year to enable the medical and operational value of CBRW to be assessed.

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¹ Jackson, D C, and Steinman, A M, *Proceedings of the National Academy of Sciences of the USA*, 1964, 51, 1192.

² McCutchan, J W, and Taylor, C L, *Journal of Applied Physiology*, 1951, 4, 121.

³ Walker, J E C, Wells, R E, and Merrill, E W, *American Journal of Medicine*, 1961, 30, 259.

⁴ Webb, P, *Journal of Applied Physiology*, 1951, 4, 378.

⁵ Guild, W J, *Journal of the Royal Naval Medical Service*, 1976, 62, 173.

⁶ Lloyd, E L, *Scottish Medical Journal*, 1972, 17, 83.

⁷ Lloyd, E L, *British Journal of Anaesthesia*, 1973, 45, 41.

Oestrogen therapy and endometrial cancer

SIR,—Your leading article on this subject (23 July, p 209) cannot be allowed to pass unchallenged.

There is no doubt that the single most controversial issue related to long-term oestrogen therapy is the possible role of such medication in the aetiology and pathogenesis of breast and uterine cancer. The imprecise nature of the relevant data does not allow full definition of the risk. The value of such data has been to create an awareness of potential risks, of abuse of potent hormones, and of the urgent need for further research and to emphasize the lack of controlled prospective clinical evaluation to date. Some perspective needs to be maintained and in this respect I can aptly quote from one of your own leading articles: "What should we do now? Smoking 20 cigarettes a day increases the risk of death from lung cancer 17-fold. The risk of oestrogens is less than that."¹

It is not, however, the cancer relationship I wish to challenge: rather it is your attempt to create controversy where none really exists. This concerns the use of oestrogens for the short-term relief of menopausal symptoms. The paper you referred to by Mulley and Mitchell² was merely a published opinion based on no direct research and a less than adequate knowledge of the existing literature. It was criticised in the correspondence columns of the *Lancet*. The only specific early symptoms of oestrogen deficiency are those related to hot flushes and atrophic vaginitis.³ In turn they have been shown to respond to short-term oestrogen therapy as tested on single-blind oestrogen-placebo cross-over studies,⁴ double-blind studies,^{5,6} in innumerable clinical reports over many years, and in the vast clinical experience. Moreover, the "mental tonic" effect of oestrogens described by myself⁷ has been confirmed by Campbell and Whitehead⁸ and by Furuholm and Fedor—Frejbergh.⁹

Your question "What should we do now?" can therefore be answered. Until specific answers are forthcoming we can keep an open

mind on the subject. In the interim it is not justifiable to withhold such therapy from the normal informed patient requesting it provided that no contraindications exist, that the patient is properly re-evaluated at frequent intervals, and that appropriate selection of drug, dosage, and therapeutic regimen is considered. Ideally, all this can be accomplished, including the necessary research, through a menopause clinic.⁹

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¹ *British Medical Journal*, 1976, 2, 791.

² Mulvey, G, and Mitchell, J R A, *Lancet*, 1976, 1, 1397.

³ Utian, W H, PhD Thesis, University of Cape Town, 1970.

⁴ Utian, W H, *South African Medical Journal*, 1972, 46, 732.

⁵ Campbell, S, et al, in *Management of the Menopausal and Postmenopausal Years*, ed S Campbell, p 149. Lancaster, MTP, 1976.

⁶ Campbell, S, and Whitehead, M, in *Clinics in Obstetrics and Gynecology*, vol 4, No 1, ed R Greenblatt and J Studd. Philadelphia, Saunders, 1977.

⁷ Utian, W H, *South African Medical Journal*, 1972, 46, 1079.

⁸ Furuholm, M, and Fedor-Freijergh, P, in *Consensus on Menopause Research*, ed P A van Keep, R B Greenblatt, and M Albeaux-Fernez, p 84. Lancaster, MTP, 1976.

⁹ Utian, W H, *Obstetrical and Gynecological Survey*, 1977, 32, 193.

Depot tranquillisers for disturbed behaviour

SIR,—I was most interested to read the letter from Drs P J Perinpanayagam and R A Haig (26 March, p 835). I have for the past two years been using fluphenazine decanoate in an average dose of 25 mg monthly to treat explosive personality disorders in both sexes, in the first year in a large mental hospital and in the past year in a mental handicap setting. I must emphasise that there was no question of psychotic illness being present in the 16 adolescents nor in the 40 older patients (in their twenties), who displayed psychopathic instability of the usual varieties—for example, self-injury such as repeated drug overdosing or wrist slashing and/or antisocial behaviour such as unreasonable aggressiveness, destructiveness, etc. Alcohol acted as at least a precipitant in a third of the cases of "difficult" behaviour. One case in particular may be of interest to your readers. A delinquent boy of 14 years with a very disturbed family background who had been placed in the care of the social services because of his destructive and life-threatening activities has apparently responded extremely well over a period of a year to fluphenazine decanoate 12.5 mg fortnightly. He has had no further episodes of absconding or getting into mischief at school or at home since starting on the drug.

I agree wholeheartedly with your correspondents that a long-acting tranquilliser can stabilise disturbed behaviour and in many cases open the way to psychotherapeutic, occupational, and other forms of rehabilitation. Thus these individuals don't seem to feel tense enough any more to inflict damage on themselves or others. I would be inclined to generalise from my own and your correspondents' experience and say that a long-acting tranquilliser is a useful means of reducing anxiety in a group classically prone to abuse oral tranquillisers.

I am conducting a mirror image study of the use of fluphenazine in ameliorating difficult behaviours in approximately 100 non-psychotic residents in a mental handicap

hospital, the majority of whom had failed to respond to other types of psychotropic medication, including a variety of other phenothiazines. The institution of the drug has coincided with a dramatic reduction in such behaviour; it remains to be seen whether cessation of the drug, which is at present being effected, will result in a resurgence of "difficult" behaviour. I hope to publish the results in due course.

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Liver biopsy in "difficult" jaundice

SIR,—We feel that the short report by Dr P Lance and his colleagues (23 July, p 236) may give an inappropriate impression of the safety and value of percutaneous liver biopsy for obstructive jaundice. We would, of course, concur with the author's view on the hazards of operating inadvertently on patients with intrahepatic cholestasis. Of 43 such patients in their series, eight underwent a laparotomy, one as a result of an incorrect percutaneous liver biopsy result. This laparotomy rate (18.6%) in intrahepatic cholestasis is unacceptable by modern standards and the dangers are adequately borne out by the 37% mortality in these patients (3/8). With the use of the full range of modern diagnostic techniques available it should now rarely be necessary to perform such laparotomy.

Concerning the important question of identification of large-duct obstruction by liver biopsy, if we exclude the operative biopsies from the authors' series 15 out of 95 percutaneous biopsies in obstructive jaundice either failed or were incorrect or unhelpful (15.8%). This indicates the known difficulty in diagnosing large duct obstruction from a needle biopsy, and indeed interpretation was incorrect or unhelpful even in 6/18 operative liver biopsies from patients with obstructive jaundice (33%). This success rate of 84% is significantly below that which has been reported by the use of grey-scale ultrasonography (GSU)¹ or fine-needle percutaneous transhepatic cholangiography (PTC).^{2,3}

Although the availability of GSU and endoscopic retrograde cholangiography is limited, PTC using the Chiba needle is easily performed and readily available. Recent communications have shown that this procedure is now being widely performed both within and outside the major teaching centres.^{4,5} PTC also has the clear advantage of providing precise anatomical location of extrahepatic obstruction.

While fine-needle PTC carries a risk, it is unlikely, particularly with the facility for percutaneous drainage of a grossly dilated biliary tree, that the risk of biliary peritonitis will be as high as that following needle liver biopsy. In addition, the use of prophylactic antibiotics appears to minimise the risk of septicæmia.⁶ There can be few experienced biliary surgeons who have not had to operate for one of these complications following a percutaneous liver biopsy in obstructive jaundice. There is now a case for restricting the use of liver biopsy to patients in whom a non-dilated biliary tree has been demonstrated by other means.

Dr Lance and his colleagues have reported a series of patients collected over the years 1959-75, an era which predates the widespread use of GSU and the Chiba needle in Britain, and their results must be accepted with

caution. While the figures quoted may be acceptable for such a retrospective series, they do not necessarily reflect current views in the practice of biliary surgery.

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¹ McKay, A J, et al, *British Journal of Surgery*. In press.

² Elias, E, *Gut*, 1976, 17, 801.

³ Benjamin, I S, et al, *Gut*. In press.

⁴ Fraser, G M, et al, *British Medical Journal*, 1976, 2, 1321.

⁵ Hinde, G de B, and Smith, P M, *British Medical Journal*, 1976, 2, 1561.

⁶ Jain, S, et al, *British Journal of Radiology*, 1977, 50, 175.

Effect of abortion on obstetric patterns

SIR,—I read with interest the interview with Professor R W Beard (23 July, p 251) and in particular the remarks made by the interviewer, corroborated by Professor Beard regarding the effect of abortion on obstetric patterns. Professor Beard implies that in Sheffield the availability of easy terminations of pregnancy has reduced the number of low-birth-weight babies and he goes on to point out how very difficult it is to deal with a woman who comes in at 26 weeks with ruptured membranes.

Surely it is an established fact^{1,2} that one or more terminations of pregnancy are liable to result in more women coming in at 26 weeks with ruptured membranes, and this would exacerbate the precise problem mentioned by Professor Beard. I would suggest that the effect on living standards which is so reasonably desired, and which might be expected to reduce the number of small-for-dates babies, is more likely to be accomplished by a sensible sterilisation campaign rather than the potentially damaging short-term solution of termination of pregnancy in young women.

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¹ Jeffcoate, TNA, *Principles of Gynaecology*, 4th edn, p 641. London, Butterworths, 1975.

² Wright, C S W, Campbell, S, and Beasley, J, *Lancet*, 1972, 1, 1278.

More hydatidiform moles?

SIR,—In the eight months from November 1976 to June 1977 nine cases of hydatidiform mole have been seen at this hospital. This is an incidence of six to seven per 2000 pregnancies where normally only one would be expected.¹

The condition is said to be more common in elderly patients of high parity and in the lower socioeconomic groups. Carr has demonstrated a high incidence of triploidy in both hydatidiform moles² and in aborted conceptions of patients who have recently used oral contraceptives.³ Thus the increase in polyploidy resulting from hormonal imbalance consequent upon recent oral contraception might be expected to give rise to an increase in the incidence of hydatidiform mole. The nine patients were questioned closely about their medical history and contraceptive habits and none had recently used oral contraceptives, nor had they any age group, blood group,