LETTERS TO THE EDITOR

Guarding paediatricians against allegations of assault

EDITOR,—The personal practice article by Chambers and Panting provided helpful information about the consent issues that surround the examination of young children.¹ However, it failed to touch on the specific problems encountered by those working in the school health service, who may find themselves examining unaccompanied children.

In April 1994, Salford Community Healthcare Trust received a complaint about the school entry medical examination of a 4 year old boy that had included examination of the child's genitalia. The parents had been sent a covering letter explaining that the child would have a full medical examination, and had signed and returned the consent form stating that they would not attend the medical. Following their complaint, the doctor concerned was suspended until the social services department had completed inquiries into the implied allegation of sexual abuse. The complaints procedure dragged on until December 1995, when external adjudicators vindicated the doctor and commented that the trust's paperwork relating to school entrant medical examinations was as good as that in many other districts.

The complaint led to a review of consent arrangements for all school health activity. Previously, vision checks, dental inspections, nursing activity and so on, had been carried out with implied consent if parents did not raise objections to a notification that their child was to be seen. The trust sought legal advice and it was suggested that express consent should be obtained for each and every contact with a member of the school health team. This would have imposed an enormous clerical workload and a pilot study resulted in only 60% of children being seen. The compromise has been to obtain signed consent annually for all mainstream primary children for the core programme of school health activity.

Medical examinations, immunisations, and contacts with children outside the core programme, still require express consent. Mainstream secondary school pupils are asked to give their own consent to meeting the school nurse for health reviews and for making use of drop-in sessions.

Initial reaction to the new arrangements was hostile. Many councillors, head teachers, and school governors felt that the arrangements were unnecessarily bureaucratic and that school health services were effectively being withdrawn from those who most needed them. The local education committee threatened judicial review, but then sought counsel's opinion in conjunction with the health authority, and informed the trust that it was 'not acting illegally' by insisting on signed consent. These fears have been largely unfounded; overall 93% of consent forms have been returned, with a number of schools including some in the most deprived wards achieving 100% return rates.

Little practical guidance about consent is available to school health staff. The Department of Health document, *Child Health in the Community: A Guide to Good Practice* issued in

September 1996 notes that 'the Department regularly receives complaints from parents who claim they were not given prior notice of an examination by the school health service'. It suggests that consent can be obtained at school entry for 'the range of developmental checks and immunisations on offer' and that parents are informed when a medical check or immunisation is planned. It also suggests that others such as therapists should be able to check that consent for an examination has been obtained. The Polnay report, *Health Needs of School Age Children*, also recommends that consent for the school health programme should be obtained at school entry.² It gives no guidance, however, on whether specific consent should be obtained for some components of the programme such as medical examinations and immunisations, and makes no comment about consent for school health activity provided by therapists and others which is outside the core programme. If consent is to be valid, it must be informed and specific for a particular treatment or programme of health care. It is difficult to see how consent obtained for a 4-5 year old could remain valid throughout that child's school career.

Annual consent has enabled us to provide parents with better information about school health services and has raised the profile of school health staff. Despite the increased workload for clerical staff and school secretaries, the new arrangements have been welcomed by the great majority of parents and schools. All those involved feel they are establishing partnerships with parents rather than delivering a hidden service which only gives feedback when problems are suspected. It remains to be seen whether the high return rate of consent forms can be maintained.

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Drs Chambers and Panting comment:

We thank Dr Smith for her comments which support our view that doctors whose practice includes children should be aware that they are not exempt from the ethical and legal requirements involved in consent for physical examination—whether the patient is accompanied or unaccompanied. Dr Smith's account illustrates this amply. We deliberately did not 'touch on' specific problems or deal with individual specialties or clinical circumstances, but wished to provide a general framework.

Readers may be interested to read a statement from the American Academy of Pediatrics Committee on Practice and Ambulatory Medicine concerning the use of chaperones in paediatrics.³

1 Chambers TL, Panting GP. Guarding paediatricians against allegations of assault. *Arch Dis Child* 1996;75:82-5.

2 Polnay L, ed. *Health needs of school age children*. London: British Paediatric Association, 1995.

3 American Academy of Pediatrics Committee on Practice and Ambulatory Medicine. The use of chaperones during the physical examination of the pediatric patient. *Pediatrics* 1996;98:1202.

Focal abnormalities detected by ¹⁸FDG PET in epileptic encephalopathies

EDITOR,—Ferrie *et al* state that 'seizures in the epileptic encephalopathies are usually considered to be primary generalised...'.¹ However the term 'primary generalised' should be used to refer to particular forms of epilepsy not seizures.

The international classification of epilepsies, epileptic syndromes, and related seizure disorders classifies epilepsies as having generalised or partial seizures.² Furthermore epilepsies are classified as symptomatic (having a known aetiology), idiopathic (no underlying cause other than a possible inherited predisposition), or cryptogenic (occult or hidden cause presumed to be symptomatic but aetiology is not known).

Idiopathic epilepsies are also designated primary. The primary epilepsies have no structural or biochemical cause, are genetically transmitted, and have a better prognosis for seizure control than symptomatic or cryptogenic epilepsies. Examples of primary generalised epilepsies are childhood absence epilepsy, epilepsy with grand mal on waking.

Lennox-Gastaut syndrome, severe myoclonic epilepsy in infancy, and myoclonic atstatic epilepsy are not examples of primary generalised epilepsies. They are cryptogenic epilepsies. The term primary generalised refers to type of epilepsy not to type of seizure. Seizures are partial or generalised or unclassifiable. Examples of generalised seizures include absence, myoclonic, clonic, tonic, tonic-clonic, and atonic seizures.

This matter of classification of epilepsies and seizures if often perceived as arcane. It is not. It is of importance that doctors treating epilepsy make all efforts to classify a child's epilepsy because from this arise decisions about appropriate investigation, likely prognosis, risk of recurrence, etc and allows proper selection of study populations.

Seizures in the epileptic encephalopathies are generalised but the term primary generalised is not appropriate. Furthermore the epilepsies included in the term epileptic encephalopathies are cryptogenic generalised epilepsies not primary generalised epilepsies.

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Drs Ferrie and Panayiotopoulos and Professor Robinson comment:

We welcome the comments of Dr Clarke regarding the significance of the syndromic diagnosis of epilepsies which our team has previously emphasised.^{3,4}

Regarding terminology, the terms 'primary' and 'secondary' epilepsies/syndromes are obsolete and have been abandoned for over 10 years 'because their meaning has been frequently misunderstood'.⁵ In both the 1985³ and 1989² international classifications 'primary' was replaced with 'idiopathic', 'secondary' with 'symptomatic'. The only occasion in which one of these terms is used is in the seizure classification⁶ for 'secondarily' generalised seizures implying an initial partial (focal) seizure progressing to a generalised one.⁶ It was in this sense that we used the term primary (primarily) generalised seizures in order to emphasise that the seizures of our patients appeared to be generalised from onset and not partial followed by secondarily generalisation. It is absolutely clear in our report that the children studied had cryptogenic epilepsy syndromes. In conclusion, we totally agree with Dr Clarke that the appropriate terminology and syndromic diagnosis should be strictly applied in epilepsies as in all other fields of medicine.

1 Ferrie CD, Maissey M, Cox T, *et al*. Focal abnormalities detected by ¹⁸FDG PET in epileptic encephalopathies. *Arch Dis Child* 1996;75:102-7.

- 2 Commission on Classification and Terminology of the International League Against Epilepsy. Proposal for revised classification of epilepsies and epileptic syndromes. *Epilepsia* 1989;30:389-99.
- 3 Panayiotopoulos CP. The diagnosis of epilepsies: still a central theme? *European Journal of Neurology* 1996;3 (suppl 3):3-8.
- 4 Grunewald RD, Panayiotopoulos CP. The diagnosis of epilepsies. *J R Coll Physicians Lond* 1996;30:122-7.
- 5 Commission on Classification and Terminology of the International League Against Epilepsy. Proposal for classification of epilepsies and epileptic syndromes. *Epilepsia* 1985;26:268-78.
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Potassium and sodium dependent glucose transport: implications for cystic fibrosis

EDITOR.—In cystic fibrosis intestine there is an increase in the rate of sodium coupled glucose absorption,¹ which exacerbates the characteristic luminal dehydration of this disease resulting from the failure of chloride secretion. The mechanism for the sodium dependent uptake of sugars from the small intestine is now well established, but early studies of its cation dependency revealed that replacement of external sodium with potassium had a greater inhibitory effect than replacement with urea or Tris.² This was explained as competition between sodium and potassium for a common binding site on the glucose transporter and it was argued that intracellular potassium might therefore displace sodium and sugar from the carrier and promote further transport by returning the carrier to a conformation suitable for membrane recycling.² Since it has recently been reported that cystic fibrosis enterocytes may possess higher intracellular potassium concentrations than non-cystic fibrosis cells,³ it is possible that enhanced sodium/glucose absorption in this disease could be a secondary effect of abnormalities in cellular potassium handling. The purpose of this study was to test whether potassium may have a direct effect on active sodium/glucose uptake using intestinal brush border membrane vesicles (BBMVs).

BBMVs were prepared from rat jejunal mucosal scrapes using a magnesium precipitation technique.⁴ Human BBMVs were prepared in a similar manner, using operative

sections of distal ileum taken from patients presenting with intestinal obstruction. All human tissues were morphologically normal and each specimen was obtained from an individual patient. BBMVs were loaded with a buffer containing additional potassium chloride or osmotically equivalent amounts of potassium gluconate, or mannitol. Glucose uptakes were determined after 60 second incubations in a buffer containing 100 mM sodium gluconate, 100 μ M ³H-D-glucose plus additional potassium chloride, potassium gluconate, or mannitol. Active (sodium dependent) glucose transport was calculated from the uptake differences in the presence or absence of phlorrhizin (250 μ M).

Active glucose uptake into rat BBMVs was significantly inhibited in the presence of 105 mM external potassium gluconate, but was stimulated when 105 mM potassium gluconate was present internally (fig 1A). This stimulation was also seen when 100 mM potassium chloride was present bilaterally, indicating that the electrogenic movement of potassium is not responsible for these changes. A similar pattern was observed using human BBMVs (fig 1B). These data are consistent with the concept of competition between sodium and potassium for the binding site on the sodium/glucose cotransporter and support the possibility that the enhanced sodium/glucose absorption in cystic fibrosis intestine may be partly attributable to defects in cellular potassium handling.

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Figure 1 Effect of internal/external potassium chloride (KCl; 100 mM), potassium gluconate (KG; 105 mM), or mannitol (M; 178 mM) on active glucose uptake into rat (A) or human (B) BBMVs; * $p < 0.05$ v mannitol only controls (Student's paired t test or one way analysis of variance as appropriate). The data indicated by shaded bars were obtained in a different experimental series from data denoted by open bars.

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Acknowledgments and authors

EDITOR.—The *cri de coeur* from Martin Moncrieff is timely. He should not be coy about being old fashioned if that is what it takes to be courteous. What he is essentially highlighting is what is universally known as the OBE, namely 'other beggar's efforts', and clearly there has been a marked increase in questionnaire distribution and publications based on time consuming completion of forms by others without due acknowledgment of their input.

However, to link those justifiable complaints to criticism about the Medical Research Council (MRC) Working Party in Childhood Leukaemia cannot go by without a response from the chairman of that group. Martin's initial problems related to a publication within the *Archives* on side effects of patients treated. One of the authors of the paper was from his own department, and a second member of the department was acknowledged as a member of the childhood working party, which currently consists of 41 paediatricians, paediatric haematologists and oncologists, plus statisticians and scientists representing each UK region, and the 22 principle paediatric oncology centres in the UK that treat over 90% of children with acute leukaemia. Since each centre makes its recommendation to the MRC as to who should represent it, we have always assumed that there was internal agreement and therefore have acknowledged merely membership of the working party. However, he will be delighted to hear that at a recent meeting of the Leukaemia Steering Committee of the MRC we have agreed that for the principle publication on any specific leukaemia trial, not only should there be the writing committee, which consists of the clinical and statistical coordinators of that trial, but the full membership of the working party, and all participating clinicians who have entered patients into the trial will also be acknowledged.

We are also considering issuing certificates of participation for individual clinicians and would appreciate feedback as to the value of such acknowledgment of help and participation. On the down side, with regard to acknowledgment, every year many hours of data management centre and of this chairman's time are spent chasing individual participants who fail to complete the forms or submit them at all for analysis. Many of the same centres do receive financial assistance to employ data managers and facilitate such returns. Inevitably participation in trials is time consuming, but it has been repeatedly demonstrated to benefit particularly children with leukaemia. The working party would wish to gratefully thank all participants. We are sorry if we have been perceived as lacking courtesy, and are only too pleased to acknowledge the diligence of so many clinicians in completing clinical data for the trials.

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- 1 Moncrieff M. Acknowledgments and authors. *Arch Dis Child* 1996;75:366.

Altruism under fire

EDITOR,—When, somewhere between the Devonian and pre-Cambrian layers on the desk, I come across at a late hour a questionnaire, I do not always oblige. It falls into the category of the discretionary rather than the obligatory, and the obligatory now consumes all our physical, moral, mental, and spiritual resources.

When I was a student, cystic fibrosis and leukaemia were both incurable. Since then, the patterns have diverged. Thanks to a series of carefully designed multicentre Medical Research Council (MRC) trials, we have treatments for leukaemia that are based on firm evidence. In contrast, much of the current treatment of cystic fibrosis is based on dogma, masquerading as science.¹ Resentment for filling in the MRC forms unless one's efforts are publicly acknowledged represents the death of altruism, yet almost all the work we do as clinicians goes without acknowledgment or thanks, and it is hard to see why one should single out for acknowledgment activity in supporting national non-profit making trials that are by their very design virtually guaranteed to help future sick children. The trouble is that we are all so besotted with throughput, productivity, personal indicators of research, teaching, and clinical performance that we don't want to allocate any time to things that don't count in the sense of being counted. This frenzy of Brownie-philis is deeply corrupting as it eats into the commitment to the common good.

Moncrieff raises the type of motivation for supporting research.² 'What's in it for me?' seems to be the question; what a lamentable response to requests for cooperation. Most students who enter medicine do so with higher ideals, and it is a grim reflection on current medical education that these ideals are so rapidly lost and replaced by the need for external motivators.³

It is naive to equate filling in surveys with doing research. However what is as yet undiscovered is a mechanism for a researcher, for example a hospital doctor in training, to participate in the design and execution of a really useful large multicentre national or international study. There probably is no mechanism, and the shift from small single centre to large multicentre studies will have an impact on the type of project that is suitable for trainee specialists who wish to do some research. Maybe the solution is to alter the emphasis from 'research' to 'research training', and offer suitable MSc courses. We need to rethink the social psychology of research when most of the data will need to be generated by people who will be somewhere in a limbo between 'et al' and 'anon'.

To question that a clinician can make a significant contribution to 10–20 publications a year was unhelpful. It certainly is possible, though it is enormously hard work. My own obsessional traits usually lead to a complete rewriting of the works of colleagues, and then helping them through the 10 to 12 versions of a manuscript that are essential if the article is to ever be worth publication. The reason that publications are important is that these are the principle means we have for conveying new information, and it is no surprise that publication quality should be used as a measure of research quality. Until one can find better forms of communication or research quality assessment, we are stuck with research papers. For heads of department to insist on authorship of all departmental

papers is plainly wrong, and Moncrieff's insinuations of impropriety are well directed.

Open any medical journal and it will be clear that much research is supported by unsung heroes. Altruism is not quite dead; it is simply under fire.

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Sleeping metabolic rate in infants

EDITOR,—The recent articles on sleeping metabolic rate (SMR) in infants are commendable in addressing the relationship between heat balance and the thermal environment.^{1,2} There is increasing awareness that this relationship may be relevant to sudden infant death syndrome.³

However, although agreeing with the authors that SMR can vary considerably between individuals due to genetic and thermal environmental factors, we suspect that the variation reported in the studies would prove less extreme if variation in body size and sleep state were taken into account.

In the first study,¹ SMR per kg body weight was assumed to be an index of SMR adjusted for body size, and differences in SMR/kg were assumed to be equivalent to differences in thermal balance. However, we have shown previously that, for a given age group, expressing metabolic rate on a per kilogram basis does not give an index of SMR that is independent of weight.⁴ Rather, SMR/kg underestimates the metabolic rate of large infants and overestimates that of small infants, whereas a mass independent index of SMR would not be related to weight. Thus the plotting of SMR/kg against age¹ is likely to have resulted in the artificial exaggeration of variation in SMR, since the effects of body size are not fully removed. This is firstly due to individual differences in body fatness, as fat free mass is the true body size determinant of SMR. However, even after taking fatness into account, a relationship between SMR/kg and body size persists,⁴ which is due to size related variation in the ratio of organs, with higher metabolic rate, to muscle tissue, with lower metabolic rate.⁵ These factors are equally applicable to the issue of surface area, where SMR expressed on a per m² basis is not constant between large and small infants.

In the second study,² repeat measurements of SMR were made on infants. In both studies measurements lasted 15 minutes, but it is generally accepted that infants sleep in cycles lasting approximately one hour, during which sleep state influences metabolic rate.⁶ During the cycles, metabolic rate has been shown to fall to a minimum of approximately 89% of the average hourly SMR value.^{4,7} Thus comparison of measurement periods that fail to take into account sleep cycle variation will almost certainly exaggerate interindividual variation, whereas comparison of mean hourly SMR or minimum SMR^{4,7} would be a more appropriate methodology.

Finally, the authors conclude that metabolic rate per unit surface area is not higher in infants compared to older age groups. It is now generally accepted that fat free mass is

the most appropriate aspect of body size in terms of which to express metabolic data.⁸ Resting energy expenditure per mass independent unit of fat free mass declines during infancy and subsequently, because the ratio of organ tissue to muscle tissue declines as the infant grows.⁹ However, mass-independent total energy expenditure is influenced additionally by physical activity level and has a more complex development with age.

We applaud the investigation of factors associated with the exchange of heat between infants and their environment, but we suggest that the extent of true variation, both between and within individuals, may have been substantially overestimated in these studies.

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Childhood cancer in schools with a radioactive lightning rod

EDITOR,—Radioactive lightening rods (RLRs) replaced conventional rods in schools built in Majorca between 1975 and 1989. RLRs in Spain usually have a bolster containing 100 mg Americium 241.¹ This isotope is an alpha emitter; its half life is 432 years. The total alpha activity on the rod is around 1.3×10^{10} Bq.

Ingestion or inhalation of radioactive particles might arise in the event of storms damaging a RLR, when contaminated radioactive material might reach the courtyard of the school where children play. Most alpha radionuclides are bone seeking.²

As one of us noticed anecdotal evidence that suggested an increase in childhood cancer in schools with RLRs, we have undertaken a population based descriptive epidemiological cross sectional study of all the 67 government funded schools in Majorca in towns with a resident population of over 6000.³ New malignancies in a total of 22 796 children age 4–14 years were identified over a 22 month period in 1990–2, from blind ques-

tionnaires sent to head teachers. A total of 162 measurements were made of radon gas and total alpha radioactivity in air using TASTRACK¹ plastic in a subsample of nine schools with and without a RLR.

Our main findings were that two malignancies were reported in 17 425 children in schools without a RLR and six malignancies in 5371 children in schools with a RLR. The rate of cancer ratio was 9.74 (95% confidence interval: 1.79 to 69.79; $\chi^2 = 11.79$, $p < 0.003$, Fisher's exact test). The radon concentration in schools with a RLR was significantly higher than in schools without a RLR ($p < 0.0001$, Mann-Whitney test). There is a significant trend for increasing alpha radioactivity from any source from schools without a RLR to schools with a RLR.

We feel that we have provided significant evidence to recommend the removal of RLRs from schools.

Since completion of this study RLRs from all schools in the island have been removed. The position in mainland Spain has changed as well: by September 1995 some 50% (13 248) of the overall number of RLRs were removed.⁵ As far as we know, in other countries RLRs remain in place.

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BOOK REVIEWS

Adaptation to Chronic Childhood Illness. By Robert J Thompson Jr and Kathryn E Gustafson. (Pp 382; £39.95 hardback.) American Psychological Association, 1996. ISBN 1-55798-327-5.

Advances in biomedical science and health care have made it possible to treat children for a range of chronic conditions, many of which would have been fatal in the past. However, the long term nature of treatment and aggressiveness of modern therapy create many difficulties for children and their families. These include the physical demands of treatment as well as psychological concerns and uncertainties about the future. Approximately 10-20% of children experience chronic conditions and continue to live full

lives; some 1-2% are more severely affected and experience much interference with daily activities.

Despite treatment demands, many children seem to cope well, though social, family, and cultural influences are determining factors. The authors adopt a largely 'non-categorical' approach which emphasises that children with chronic conditions face common life experiences and difficulties based on generic dimensions rather than idiosyncratic characteristics of a specific disease. Although much of the book focuses on processes of adaptation to chronic disease, separate chapters are given over to specific topics, including compliance. The book scores in its approach of introducing some of the basic assumptions underlying psychological methods and theories.

Interest in psychosocial issues in chronic disease is currently high, fuelled by increases in survival in many conditions, and newer emerging issues (for example quality of life in children undergoing new treatments). In addition, recent NHS research and development initiatives have done much to raise the profile of quality of life in patients.

Research concerned with psychosocial consequences of chronic illness should not, however, be an academic exercise. There are implications for policy decisions, especially with regard to the education and follow up care of sick children. As an exposé on contemporary issues (at least as viewed by the US health services), this book is an excellent review. Straightforward extrapolations to the British context are difficult. First, there are obvious differences in organisation and delivery of health care services. Second, there are differences in research methods. Outcome measures and questionnaires tend to be developed for US samples and are not always appropriate for work here. US samples appear to be much more compliant than British; commonly used measures tend to be much too long and cumbersome to be acceptable here. Third, there are differences in theoretical approach. In this, approaches in the US appear more sophisticated than here, at least at present.

Much has been written in recent years about the difficulties faced by children and this book provides an up-to-date summary of many of the key findings. There is also some attempt to suggest what can be done—though this literature is inevitably smaller. Interventions focus largely on reintegrating the child into school or helping families cope, particularly where compliance is a problem. The chapter dealing with pain is specially helpful, perhaps because in this context, psychological interventions seem to be particularly promising.

Psychology and paediatrics share a commitment to the realisation of the child's full potential. In developing a comprehensive service for the child with a chronic disease, there is much scope for collaboration.

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Reader in health psychology

Atlas of Bone Scintigraphy in the Pathological Paediatric Skeleton. By Isky Gordon, Sibylle Fischer, and Klaus Hahn. (Pp 343; £94.50 hardback.) Springer-Verlag, 1996. ISBN 3-540-60471-5.

As a radiologist with an interest in paediatric radiology and therefore also an interest but no great expertise in paediatric nuclear medi-

cine, I welcomed the opportunity to review this book and see what I learned from it. It contains mainly images of bone scintigrams and descriptions of the findings. These are presented in sections on infection, tumours, trauma, etc. The similarity in appearance of a number of different pathological conditions is noted confirming the high sensitivity but lower specificity of skeletal scintigraphy, a fact which is readily acknowledged by the authors. Some of the descriptions of the images are accompanied by 'teaching points' and 'technical comments'. The teaching points deal with the interpretation of the images and highlight the pitfalls of that interpretation as well as dealing with some of the less usual appearances of certain conditions. The technical comments are mostly confined to comments on positioning and misleading appearances where isotope has extravasated at the injection site. In places there are useful cross references to other conditions where similar appearances may also be seen.

I did learn something from reading this book but its main value to me will be in the future when I will use it as a reference to confirm whether a particular appearance is consistent with a particular pathological process or not. It will also allow me to be more confident in including or excluding other processes which may give similar appearances. I can foresee this book being used in a similar way by many general nuclear medicine departments which undertake paediatric bone scintigraphy in the context of a larger adult workload. It will also be useful as a teaching aid for nuclear medicine trainees. An atlas is not intended to provide large amounts of factual information but is dependent on the quality of its images and in this text these are mostly of a high standard. This atlas complements well the *Atlas of Bone Scintigraphy in the Developing Paediatric Skeleton* previously published by the same authors and produced under the auspices of the Paediatric Committee of the European Association of Nuclear Medicine.

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Immunologic Disorders in Infants and Children. 4th Ed. Edited by E Richard Stiehm. (Pp 1084; £198 hardback.) Harcourt Brace, 1996. ISBN 0-7216-4948-3.

One problem with multiauthor textbooks is the cost—unless of course you are fortunate enough to be asked to review one for a journal. The other is that they take so long to write, compile, and publish that they may not offer current information, particularly if you don't rush out and buy them in the month they appear or if you have already owned them for a year or two—and it is reasonable to expect a year or two's use out of a book of this size. On the other hand, despite the recent appearance of web browsers in our desks, for most of us the reference book remains the first and most convenient rapid source of information when we need to tackle a difficult or unusual clinical problem, at least for the moment. For this purpose, in the field of paediatric immunology, there is no alternative to this book at present. A number of shorter handbooks exist as well as short clinical sections in textbooks of basic immunology. The subject is also covered briefly within various large textbooks of paediatrics, paediatric infectious diseases, and haematology.

However, as far as I know, this book is the only full length clinical textbook devoted entirely to this area. Although it would be fair to summarise the consensus on the previous edition of Stiehm as being that it failed satisfactorily to fulfil the role it had set itself, initial impressions of this new edition—I have been using it now a little over a month—are that it does a much better job. For example it successfully led me to a diagnosis I had never heard of (Schinmke's syndrome) in clinic recently and delivered the relevant recent literature. It has also provided some valuable background and practical material upon which to base teaching on HIV disease despite the fact that this must be one of the fastest changing areas of clinical paediatrics. It is worth mentioning that the book does not restrict itself to discussion of immunodeficiency states, but also steals back some of the bookshelf space from other tomes with useful material on basic, clinical, and pathological aspects of the immunology of a comprehensive range of autoimmune and inflammatory disorders in different organs and systems. Of course I have my copy—if I had been browsing through some one else's over the last months I would now be ordering my own—but then I am a paediatric immunologist. If you aren't you may prefer to locate a copy you can get access to from time to time.

ADAM FINN

Senior lecturer in paediatric infectious diseases and immunology

Preschool Children with Inadequate Communication: Developmental Language Disorder, Autism, Mental Deficiency. Edited by Isabelle Rapin. (Pp 299; £45 hardback.) Mac Keith Press, 1996. ISBN 1-898-68307-7.

As a clinician, one of the most difficult tasks that I repeatedly face is the assessment of a preschool child who has been referred because of concerns regarding the child's language acquisition, but nearly always there is the concomitant worry from the parents about 'other odd behaviours'. I know immediately that I am entering the diagnostic dilemma of social and communication developmental disorders. I am also very aware of the relative limitations in our knowledge regarding certain aspects of these children's functioning and particularly regarding prognosis that parents are bound to raise. Any rigorous research that furthers our thinking about the aetiology and clinical picture of these disorders so we can diagnostically differentiate such categories as developmental language disorder is to be welcomed. This monograph edited by Isabelle Rapin has addressed many of these issues. While at present the vast amount of data presented reflects the previous functioning of these children, the great strength will be future data generated from the proposed longitudinal component of this study.

The monograph describes the extremely detailed evaluation of four groups of children with developmental neurobehavioural disabilities. The four groups are higher functioning autistic children, autistic children with lower IQs, children with developmental language delay, and children with low non-verbal IQ who are not autistic.

Batteries of well validated assessment instruments were used to assess the children. Interestingly, the volume also includes the

first publication of two new assessment instruments, the 'Wing Schedule of Handicaps, Behaviour and Skills' and the 'Wing Autistic Disorder Interview Checklist' (WADIC).

Descriptions of particular clinical differentiations prove most interesting. For example, the value of performing a rigorous neurological examination on these children was discussed. While the overall conclusion was that this provided little additional information to the assessment and diagnostic issues, it highlighted some differences that may have aetiological importance. The finding of macrocephaly in some autistic children was confirmed. This finding occurred most often in higher functioning autistic children. This has been previously postulated as representing or suggesting atypical brain development, such as the lack of normal pruning of redundant cells or connections that would mark optimal maturation of the nervous system. Due to methodological constraints, there can only be supportive evidence for particular aetiological theories. This was forthcoming in support for the notion that developmental language disorder and autism are aetiologically distinct. Children with developmental language delay have more family members with reading and spelling difficulties, while there is a higher incidence of autistic disorder among siblings. There was no support for the claims of recent associations between autistic disorder and either Gilles de la Tourette's syndrome or manic depressive disorder. Other interesting associations were epilepsy syndromes with the lower functioning autistic children and the non-autistic lower functioning children. Both groups of autistic children had higher incidence of sleep problems, and parents more often reported loss of skills within the autistic group rather than those with developmental language disorders.

These clinical details are not only of theoretical interest but provide some important directions for therapeutic interventions. An example comes from the data provided on the neuropsychological profiles. In the higher functioning autistic group this included normal non-verbal ability but poor self organisation of connected speech, poor pragmatic and impaired socialisation, inadequate language comprehension but a relatively stronger confrontation naming and written language skills. The children had better short term auditory verbal memory for non-meaningful material than for meaningful material with a particular strength in rote learning and long term memory. The authors point out that it is crucial to remember when assessing these children not to judge their language comprehension from their output, as they do not exhibit the more typical pattern of better comprehension than expression of language seen in most language impaired children. This sort of detail can be very influential in the educational approaches to these groups of children.

While the monograph raised some very interesting aetiological questions and discussions regarding proposed classificatory systems, it was for the wealth of informative clinical detail and potential this may have for making one's assessments and therapeutic interventions that I found this text most valuable.

MARIAN PERKINS

Consultant child and adolescent neuropsychiatrist

Clinical Risk Management. Edited by Charles Vincent. (Pp 588; £34.95 paperback.) BMJ Publishing Group, 1996. ISBN 0-7279-0947-9.

When the first conference on clinical risk management in this country was held in Oxford in 1989, there was very little experience here and the meeting had to draw heavily on experts from California, many of whom have contributed to this book. Since then, the position has changed quite dramatically. There can now be few doctors and nurses and even fewer health service managers who remain unaware of the size of the problem of medical litigation and of the implications for trusts. The publication of this book is therefore very timely.

The approach taken by the editor is to gather together a wide range of experts from the several disciplines concerned so that all aspects of clinical risk management can be covered and a comprehensive picture presented. The book should be seen as a handbook and a source of reference, so that different readers can select those chapters which provide the guidance and background they need.

The subjects covered range from general principles through risk management in high risk specialties to various important tasks in implementation and claims management. All the chapters will repay a quick read, while many can be strongly recommended for all clinical and non-clinical managers.

Some idea of the scope of the book can be obtained by my referring to some of the contributions which I would list as essential reading. James Reason's outline of the human factors involved in adverse events and the importance of organisational decisions helps to encourage a new and wider understanding of accidents and why they occur. I find his various distinctions, for example between slips, lapses and mistakes, of considerable assistance in clarifying in one's mind just what we are up against in reducing risk. Robert Dingwall and Paul Fenn provide a chapter on financial implications and draw attention to the opportunity costs of risk management procedures and the estimated costs of alternatives such as no-fault schemes. Fiona Moss has the difficult but rewarding aim of placing risk management within the 'clutch of programmes' introduced to improve the quality of medical care. Laura Morlock writes about evaluation of clinical risk management programmes in the USA, giving her valuable views on what has been learnt there over 20 years.

There are 10 chapters on reducing risks in clinical practice. The specialties covered include obstetrics, paediatrics and neonatal intensive care, anaesthesia, urology and general surgery, orthopaedics, and accident and emergency medicine. General practice is also included, as is psychiatry, nursing, and midwifery. These chapters should be read and considered within the appropriate divisions, bearing in mind that several dwell on what can go wrong rather than on experience gained in risk reduction. These should be used to encourage further work and pilot schemes necessary if the possibilities of clinical risk management are to be explored.

The introduction of clinical risk management is covered in the final chapters, starting with a contribution on 'essentials' from Roger Clements, based on his long experience. The chapter on the central issue of incident reporting systems is interestingly covered by a joint presentation which draws from USA

and UK experience (by Orley Lindgren and Jonathan Secker-Walker). The final chapters pick up on important issues such as clinical complaints, alternative dispute resolution, support for staff involved in litigation, and a guide for hospital claims managers on what has been one of the most encouraging developments in recent years, namely the better handling of claims by staff with more training and support than before.

It is right and proper that the editor Charles Vincent's chapter, on how to care for patients harmed by treatment, is one of the most essential for clinicians to read and consider. Clinical directors could use this chapter and its concluding suggestions as a checklist to see how well their specialties are doing.

The nearly 600 pages (including some useful appendices) could well be criticised for length, repetitiveness, and variability in the standard of chapters. But if used as intended, as a source of reference and an attempt to provide a comprehensive outline of the current state of the art, it will meet the present needs of many clinicians and managers. In the period since it has been published, important changes have occurred, such as the introduction of the new clinical complaints procedure and the publication of Lord Woolf's final report on improving access to justice. It is likely that with the speed of these and other changes, a second edition will be necessary quite soon.

ALEX GATHERER
Clinical risk research associate

Poverty and Child Health. Edited by Nick Spencer. (Pp 249; £18.50 paperback.) Radcliffe Medical Press, 1996. ISBN 1-857775-068-3.

Are there really still poor people in Britain? Will the poor always be with us? Can the health service do anything about it anyway? Never a disbeliever in poverty, I have become a sceptic of late on the possibilities of doctors making a difference. But no longer, after reading *Poverty and Child Health*. It challenged me, gave me fresh ammunition, and provided some very good pointers for action. And, indeed, action is needed, by our college and by every paediatrician in the country, if we are to reverse the horrendous slide into inequality evident in the UK in the mid-90s.

Poverty and Child Health is an academic book but not a book just for academics. It is highly readable, and the clarity of the print and the prose is remarkable, as are the end of chapter summaries effective. Spencer does not generally overstate the case, though I did detect one example of hyperbole: the association of iron deficiency anaemia with socioeconomic status is by no means as strong as he suggests.

Spencer takes a genuinely international perspective, and this is valuable particularly as some of the best examples of poverty reduction are from outside Europe. Sri Lanka and Kerala do outstandingly well through their emphasis on education for all and equitable income distribution, while Brazil is spectacularly bad as the rich get richer, and the poor poorer. But surely our poor aren't that poor? Spencer devotes 17 pages to defining and measuring poverty, and these are a must.

The Jarman index gets a thumbs down, Townsend a modest cheer. While the European Union defines poverty as income less than 50% national average, the author

stresses the value of measures of income inequality. I now know to use the Gini coefficient to compare income inequality between countries.

The middle of the book covers familiar territory on the evidence for links between poverty and child health and the causal debate, filled with clear figures and tables. The section on ethnicity and race—not at all the same, as some might think—is another gem. Spencer comes down firmly in the 'structural' camp as opposed to behaviour as the main cause of poverty, and who could disagree with his logic? Few outside the bounded horizon of the present government. The exposition on nutrition and child health is another excellent section (what are the cheapest sources of calories in UK? Meat pies, sausages, chips, and Mars bars).

Only 11 pages are devoted to health service approaches, which is partly because of the relative ineffectiveness of health service action, and partly because effective solutions are scanty. The principles are well drawn: equity, empowerment, data monitoring, advocacy, and accessibility are central. The example of Australia is highlighted: there, specific targets are set for disadvantaged groups. Sandwell is one of the few health authorities in UK to have used a similar approach. Health education advice is sadly ineffective in bridging the gap between rich and poor.

Spencer ends with pointers for future research. What better agenda for the research unit of our new college?

TONY WATERSTON
Consultant paediatrician

Pediatric Otolaryngology. Vols 1 and 2. 3rd Ed. Edited by C Bluestone, S Stool, and M Kenna. (Pp1677; £252 hardback.) W B Saunders, 1996. ISBN 0-7216-5246-8.

The arrival of a new edition of a classic textbook may evoke mixed feelings. There may be excitement associated with the anticipation of perusing a familiar and respected text now 'even better' than before. One may be optimistic that improvements have been made in style and layout and that the content has been brought up to date. In contrast anxiety may develop that the edition on one's own shelf will be rendered obsolete. Will it be worth consulting when there may be some new, cutting-edge treatment described in the new edition? At a stroke the previously prized tome may have been devalued. Should one—must one—buy the new edition?

The resolution of this conundrum rather depends on the nature of the book and the way one hopes to use it. If looking for detailed information on the unchanging aspects of a subject such as, dare I say it, embryology, symptoms, signs, etc a new edition may simply confirm that *la plus ça change....* If one is searching for up to the minute references one may be pleased at all the new material cited but disappointed that all references are at least a year old. But if simply looking for a 'place to start'—a clear statement of accepted practice, details of new and emerging developments, and a comprehensive review of the literature—one is often happy to consider buying a new edition.

Bluestone, Stool, and Kenna bring us the third edition of their classic textbook on paediatric otolaryngology six years after the second. I suspect that most owners of the previous edition will want to replace it with the

new. All aspects of paediatric otolaryngological practice are covered, reconfirming it as a major resource in its field and guaranteeing its usefulness in all paediatric and otolaryngological libraries. In the six years since the last edition there have been major advances in the field and the authors have succeeded in including these in the new edition. Coverage of some of the newer areas is a little 'light'; four and a half pages on cochlear implants seems inappropriate when the same space is given to foreign bodies in the nose. None the less the book is comprehensive.

The authors hope their readers will use the book as a reference source. If they do, they will not be disappointed. Reference lists are up-to-date and the authors have identified in each chapter a short list of particularly useful 'selected references' upon which they have provided specific comments.

As with many multiauthor textbooks, this one lacks homogeneity. Nowhere is this more apparent than in the illustrations. A significant proportion are 'borrowed' from other publications and standards vary widely. The particularly poor quality of many of the black and white photographs is my only concern but is the only major technical criticism of a book which is otherwise well produced. It is only disappointing that once again the ubiquitous North American shiny paper, so difficult to read under a reading lamp, has been used.

All in all a worthy new edition of a classic text.

MARTIN J BURTON
Consultant otolaryngologist

Children's Medicine and Surgery. By Forrester Cockburn, Robert Carachi, Krishna N Goel, and Daniel G Young. (Pp 539; £42 paperback.) Arnold, 1996. ISBN 0-340-55143-7.

A paediatric text that is attractively presented, easy and entertaining to read, and beautifully illustrated, as this is, is much needed to provide a sound basis in paediatrics and paediatric surgery for medical students and senior house officers. The authors have provided a broad picture of common paediatric conditions with a useful insight into the pathophysiology. I would have liked to have seen more discussion of some of the many controversial issues existing in medical practice. I also feel that it would have been worthwhile appraising current national management guidelines. The text, I would suggest, does not cover rare paediatric conditions in sufficient detail to be suitable for candidates embarking on MRCP part 2. However, the illustrations in themselves virtually constitute a colour atlas of paediatrics, making the book a worthwhile addition to the reading material of all paediatricians in training.

J A DUDLEY
Specialist registrar

Therapeutic Guidelines in Paediatric Infections. By S Nadel, R Heyderman, N Klein. (Pp 52; £9.99 paperback.) Chapman and Hall, 1996. ISBN 0-412-78430-0.

Interest in infectious diseases in childhood seems to be enjoying a renaissance, perhaps because there is a growing realisation that infectious diseases have not gone away despite mass vaccination and antimicrobial chemotherapy. Indeed, new infections such

as HIV have emerged, old infections such as tuberculosis are proving more troublesome and others, such as group A streptococcal disease, seem to be changing their characteristics. Furthermore, while antibiotics have been immensely useful, organisms such as the methicillin resistant *Staphylococcus aureus* and penicillin resistant pneumococci demonstrate the need for an up-to-date awareness of changing antibiotic sensitivity.

This very readable little book is well laid out with some very clear tables. It opens with an excellent brief section on assessing infection, thinking through the likely causative agents, and deciding on the best choice of antibiotic. The commonly used antibiotic agents are well described followed by chapters on treatment for specific infective syndromes and infection with specific organisms. Dosage schedules for commonly used antimicrobials are tabulated and the book closes with an excellent section on microbiological specimen collection, a subject often overlooked by clinicians who fail to appreciate that a laboratory can only give good information if it receives the right specimens at the right time.

This is a brief work, so it is not as comprehensive as its North American counterparts, nor does it have the same scope as the superb British Paediatric Association* *Manual of Childhood Infections*. Nevertheless, it very

much succeeds in its aim of being a quick and easily accessible source of information to aid diagnosis and treatment of children suffering from acute infections.

ANDREW J CANT

Consultant in paediatric immunology and infectious diseases

*Now the Royal College of Paediatrics and Child Health.

Epilepsy in Children. Edited by Sheila Wallace. (Pp 647; £95 hardback.) Chapman and Hall Medical, 1995. ISBN 0-412-56860-8.

Epilepsy in Children is a significant contribution to the paediatric neurology literature. This is a multiauthor text book with many contributions from leading figures in the world of paediatric epileptology. This volume is for the clinician. It is comprehensive with excellent references and should become a standard text for any physician with an interest in paediatric epilepsy.

The book is divided into logical sections dealing with every aspect of childhood epilepsy from epidemiology and aetiology through to treatment, specialist services for epilepsy, and childhood epilepsy evolving into adult epilepsy. The strength of this book is its

clinical approach, with clear discussion of the various electroclinical syndromes now recognised in paediatric epileptology and their division by age of onset. In this book the epileptic syndromes have come of age.

I could find very few faults. Section 6 on the cellular mechanisms of epilepsy does require careful reading. I found this section quite difficult and would have preferred a more simplified discussion, but suspect that this reveals my own weakness in this area.

This is an excellent volume, well referenced, and up-to-date. I would strongly recommend it to readers of the *Archives* and would hope that every paediatric unit in the UK would have a copy available for reference.

M A McSHANE

Consultant in paediatric neurology

Referee update

We would like to apologise to Ishaq Ahmad Abu-Arafeh, whose name was truncated, and to Dr C R J C Newton, whose name was omitted from the referee list published in December 1996.