- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

Deaths from haemolytic disease of the newborn in 1990

SIR,—We recently analysed deaths from rhesus haemolytic disease in England and Wales in 1988 and 1989 and showed that whereas before 1988 the decline in deaths due to Rh haemolytic disease had been gradual, in 1989 the death rate suddenly halved; we wondered whether this was a chance finding.¹ We now report the figures for 1990.

The table gives details for the three years 1988-90. The figures for 1990 are extremely similar to those for 1989, suggesting that 1988 was not a hiccup. Probably a combination of factors has saved lives—namely, improved obstetric care, fewer omissions of anti-D prophylaxis, and, possibly, more anti-D immunoglobulin being given for specific bleeding events during preg-

stationary (G J Dovey, personal communication) since the decline levelled out in about 1985.

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1 Hussey RM, Clarke CA. Deaths from Rh haemolytic disease in England and Wales in 1988 and 1989. *BMJ* 1991;303:445-6. (24 August.)

adequate medical and nursing staffing for these patients, which will need to be considered by those concerned with planning paediatric services.^{3,4}

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- 1 *Communicable Disease Report* 1991;1:228.
- 2 Lebel MH, Gauthier M, Lacroix J, Rousseau E, Buithieu M. Respiratory failure and mechanical ventilation in severe bronchiolitis. *Arch Dis Child* 1989;64:1431-7.
- 3 Piftis K, Everard M, Milner AD. Outcome of severe acute bronchiolitis needing mechanical ventilation. *Lancet* 1990;335:607.
- 4 Mulholland EK, Olinsky A, Shann FA. Clinical findings and severity of acute bronchiolitis. *Lancet* 1990;335:1259-61.

Epidemic of bronchiolitis in infants

SIR,—Our recent experience suggests that the epidemic of bronchiolitis due to respiratory syncytial virus in infants this winter has been more extensive and severe than usual. This clinical impression is supported by data from the Communicable Diseases Centre, whose four weekly returns of infections with respiratory syncytial virus (of which 88% were in children under 1 year old) show a pronounced increase for the four weeks ending 31 December 1991 over the same period in 1989 and 1990.¹ We have also had a greater number of severe cases requiring intermittent positive pressure ventilation and would be interested to know if comparable units have had similar experiences.

In the past three months the paediatric department at this district general hospital has needed to ventilate 10 babies aged between 1 week and 3 months admitted with viral bronchiolitis. Of these, six had been born prematurely at 25-36 weeks' gestation, two had been born at term and had congenital heart disorders, and two were previously healthy babies who had been born at or near term. Eight of the infants were confirmed as being positive for respiratory syncytial virus.

Nine infants survived after intensive supportive treatment, including intermittent positive pressure ventilation. One infant born at 30 weeks' gestation and suffering from severe hyaline membrane disease died aged 11 weeks despite the use of ribavirin. All but one of the infants received intermittent positive pressure ventilation in the high dependency area of a general children's ward, thus throwing a considerable extra workload on nursing and medical staff.

With the increasing numbers of vulnerable babies, in particular those born prematurely and infants suffering from congenital heart disorders, this pattern of severe bronchiolitis seems likely to be repeated in subsequent winters.² This has considerable implications for the provision of appropriate intensive care accommodation and

Prison medicine

SIR,—Richard Smith's editorial makes a powerful case for major reorganisation of the prison medical service to bring it more closely into line with the reformed NHS.¹ A recent consultation document produced jointly by the Home Office and the Department of Health considered issues of contracting and medical management in some detail.² The report recommended that a reorganised, renamed prison health service should become a purchaser, commissioning a full range of health care services from the NHS and other providers. Smith argues that this does not go far enough and asks, "Why should the purchasing not also be done by the NHS?"

District health authorities will be well ahead of the prison health service in developing purchasing. They have input from public health departments, which are making rapid progress in health needs assessment and evaluating health care delivery. Public health skills are a vital component of NHS purchasing; it is difficult to envisage how prison health services would develop purchasing plans and contract specifications without this skill.

Responding to the consultation document, the regional directors of public health have welcomed these proposals for greater integration of the NHS and health care in prisons. They believe that this will lead to better services for prisoners and improved training and support for prison health staff. As well as recognising potential benefits at provider level we support Smith in advocating the involvement of district health authorities and family health services authorities as purchasers. Regarding prison populations as resident within their host health authority leads to these authorities having clear responsibilities under the NHS reforms to assess health needs and commission the best package of health services to meet those needs.

The complexity of these changes must not be underestimated. Integration at provider level will require adequate resourcing in terms of money,

Classification of deaths registered by Office of Population Censuses and Surveys as due to haemolytic disease of fetus or newborn

Category	1988	1989	1990
<i>Deaths due to anti-D*</i>			
1a	3	2	
1b	5	5	5
2	6	2	3
3	6	1	2
4	0	0	1
Total	20	10	11
Deaths/100 000 live births	2.9	1.5	1.6
<i>Haemolytic disease due to antibody other than anti-D (anti-C, anti-Kell, etc)</i>			
5	4	3	4
<i>Deaths not due to haemolytic disease (that is, excluded after scrutiny of notes)</i>			
6	7	10	8
Total deaths registered as due to haemolytic disease	31	23	23
Deaths of liveborn infants			6
Stillbirths			9

*Category 1: mother believed to have been immunised by pregnancy after which she was not given injection of anti-Rh immunoglobulin (category 1a: immunising pregnancy occurred before 1970 (when anti-Rh immunoglobulin not widely available); category 1b: immunising pregnancy occurred from 1970 onwards). Category 2: mother immunised during first pregnancy (anti-D detected during or within seven days after first pregnancy). Category 3: mother immunised despite having been given anti-Rh immunoglobulin after one or more previous pregnancies (failure of prophylaxis). Category 4: mother immunised by blood transfusion.

nancy. Interestingly, in 1990 a third of all the deaths from haemolytic disease of the newborn were due to antibodies other than anti-D (three anti-Kell and one anti-C) compared with 4% in 1977, supporting the value of prophylactic anti-D immunoglobulin.

Investigations are still proceeding as to why new immunisations due to D antigen have remained