dispensing of controlled drugs are being introduced.

We are concerned that the implications, and possibly unintended consequences, of the new guidance have not been widely recognised or publicised to paediatricians and child psychiatrists.

We first became aware of changes to prescribing policy after several phone calls from local pharmacists refusing to issue more than 28 days supply of methylphenidate for our patients with attention deficit hyperactivity disorder, and so we sought further clarification.

Changes will be introduced, subject to parliamentary approval, in the summer of 2006. In some cases the changes will be effected through professional guidance, and in other cases through further amendment to the Misuse of Drugs Act Regulations (http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4131465&chk=qsfb19). The key issues affecting paediatricians are the following:

- Duration of any prescription for schedule 2 (eg, methylphenidate 2, which is a controlled drug), 3 and 4 controlled drugs should be restricted to 28 days.
- Introduction of 28-day maximum quantity on prescriptions for schedule 2, 3 and 4 controlled drugs.
- In future, prescriptions should be printed rather than hand written.
- Re-emphasis of professional guidance that doctors should prescribe controlled drugs for themselves or family members only in exceptional circumstances.

Clearly, it will have a huge effect on the paediatric prescribing workload if we had to issue monthly repeat prescriptions for all children on methylphenidate. Further discussion with The Department of Health showed that in exceptional circumstances where the prescriber believes that it is clinically indicated and would not pose an unacceptable risk to patient safety, a prescription for >28 days, may be allowed. It was suggested that the trust "Prescribing Lead" highlight the issue of methylphenidate with local pharmacies and that the issue of methylphenidate be specifically considered in the future.

In the short term, paediatricians need to be ready to justify their prescribing decisions and need to be aware that prescriptions for >28 days' supply may not be dispensed; they may then wish to invest in a departmental prescription printer!

A C Baverstock, F Finlay, S Lenton
Community Child Health Department, Newbridge Hill,
Bath, UK

Correspondence to: A C Baverstock, Research Registrar, Community Child Health, Department, Newbridge Hill, Bath BA1 3QE, UK; annabav@hotmail.com

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Diagnostic value of skull x rays in infants with plagiocephaly

A national survey concluded that the management of deformational plagiocephaly

among paediatricians and neurosurgeons in the UK was very varied and lacked national guidance.¹

A large number of people arranged for a skull x ray to be taken in cases of suspected craniosynostosis, severe deformity or if symptoms were not resolving.

We reviewed the literature to determine the utility of a skull x ray in lambdoid synostosis in otherwise normal infants presenting with plagiocephaly.

A skull x ray that shows the entire length of the lambdoid suture to be patent rules out lambdoid synostosis.² Radiographic features such as obliteration or fusion of the suture and heaping up of bone are definitive of synostosis.³⁻⁴ However, the x ray may show deformed or depressed petrous bone, sclerosis along the suture line⁵ or indistinctness of the suture,⁴ all of which may represent synostosis.⁶

The definitive investigation for suspected craniosynostosis is a multidetector computed tomography scan with three-dimensional reconstruction. This requires high doses of radiation and therefore skull x rays are likely to continue to be the initial investigation in cases of clinical uncertainty.⁷

However, clinicians must note that interpretation of the skull x ray in these infants may not be straightforward and may not always give a clear answer.

A Neelakantan, L Watson
Teversham, Cambridge, UK

Correspondence to: A Neelakantan, 27 Lady Jermy Way, Teversham, Cambridge CB15BE, UK; neeluasha@yahoo.co.in

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References

- 1 **Rajendra B**, Amegavie L, May P, et al. G200 National survey on deformational plagiocephaly and the use of cranial moulding devices. *Arch Dis Child* 2006;**91**:A71-3.
- 2 **Menard RM**, David DJ. Unilateral lambdoid synostosis: morphological characteristics. *J Craniofac Surg* 1998;**9**:240-6.
- 3 **Benson ML**, Oliverio PJ, Yue NC, et al. Primary craniosynostosis: imaging features. *Am J Roentgenol* 1996;**166**:697-703.
- 4 **Fernbach SK**, Feinstein KA. Radiologic evaluation of a child with craniosynostosis. *Neurosurg Clin N Am* 1991;**2**:569-85.
- 5 **Rollins N**, Sklar F. Facitious lambdoid perisutural sclerosis: does the "sticky suture" exist? *Pediatr Radiol* 1996;**26**:356-8.
- 6 **O'Broin ES**, Allcutt D, Earley MJ. Posterior plagiocephaly: proactive conservative management. *Br J Plast Surg* 1999;**52**:18-23.
- 7 **Persing J**, James H, Swanson J, et al. Prevention and management of positional skull deformities in infants. *Paediatrics* 2003;**112**:199-202.

Breast feeding and the Baby Friendly Initiative: is the training of doctors being ignored?

Breast feeding is an unequalled way of providing ideal food for the healthy growth and development of infants. It is also an integral part of the reproductive process, with important implications for the health of mothers. As a global public health recommendation, infants should be exclusively breast fed for the first 6 months of life to achieve optimal growth, development and health.¹ To promote this, the Baby-Friendly

Hospital Initiative was launched in 1991 by Unicef and the World Health Organization and recommended 10 steps for successful breast feeding, the attainment of which would give the health establishment a baby-friendly status. Step 2 aims to "train all healthcare staff in the skills necessary to implement this policy".² Crucially, fulfilment of this criterion is met by training midwives, health visitors and nurses, and does not include doctors.

The level of training varies among different health professionals, with most midwives and health visitors undergoing a 2-3-day breast-feeding awareness course. Doctors need less extensive training, but they still require information to enable them to provide effective support for breast feeding. The lack of breast-feeding knowledge and skills in paediatric trainees has been previously commented on in the UK³ and elsewhere.⁴

We assessed the level of knowledge of paediatric trainees in this regard. A questionnaire was given via telephone to paediatric senior house officers working in all 14 neonatal units in Wales from November 2003 to January 2004; 77 of the 87 (88.5%) doctors responded.

Of the 77 doctors, 14 (18%) had not received any training related to breast feeding in their present job; interestingly, this lack of training was similar in those units that had achieved baby-friendly status as compared with those that had not. The training, where present, was mostly in the form of a lecture. In all, 58 (75%) of the trainees were aware that babies should be exclusively breast-fed for the first 4-6 months. Only 30 (39%) knew that mothers of babies in special care baby units needed to express breast milk at least 6-8 times per day, including at night. Only 44 doctors (57%) had any idea of the baby-friendly initiative.

We strongly urge hospital trusts and paediatric departments to encourage their training doctors to learn about breast feeding. In this endeavour, they may find the recently available teaching packs for paediatricians and general practitioners at www.babyfriendly.org.uk useful.

R S Arora
Royal Manchester Childrens Hospital, Manchester, UK

C Doherty
University Hospital of Wales, Cardiff, Wales

Correspondence to: R S Arora, 19 Wet Earth Green, Swinton, Manchester M27 8AL, UK; reemaraman@doctors.org.uk

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References

- 1 **World Health Organization**. *Global strategy for infant and young child feeding*. Geneva: World Health Organization, 2003.
- 2 **UNICEF UK Baby Friendly Initiative**. *Implementing the Baby Friendly best practice standards*. London: UNICEF UK Baby Friendly Initiative, March 2001 (online version updated December 2003).
- 3 **Northern Ireland Breastfeeding Strategy Group**. *Breastfeeding Strategy for Northern Ireland*. Belfast: Department of Health and Social Services, 1999.
- 4 **Freed GL**, Clark SJ, Lohr JA, et al. Pediatrician involvement in breast-feeding promotion: a national study of residents and practitioners. *Pediatrics* 1995;**96**:490-4.