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- 2 Havas TE, Motbey JA, Gullane PL. Prevalence of incidental abnormalities on computed tomographic scans of the paranasal sinuses. *Arch Otolaryngol Head Neck Surg* 1988;114:856-9.
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Author's reply

EDITOR,—I believe that the points raised by Alexander C MacLennan and Gerald W McGarry were addressed in my review. In fact, we both reference the same paper for the same reason.¹ When an overview of a broad subject is presented to the medical profession as a whole it is possible to imply an inappropriate emphasis on one investigation. I did not, however, imply that computed tomography should be relied on for diagnosing chronic sinusitis; indeed, I stated that it should be requested only "after failure of maximal medical treatment, if a complication arises, or if malignancy is suspected."

I agree that rigid nasal endoscopy is important in diagnosing chronic sinusitis, but it cannot stand alone as a diagnostic investigation as it also has limitations as already stated—for example, the inability to identify concha bullosa or Haller's cells. Not all patients are able to tolerate the middle meatus being inspected with a rigid endoscope, and if they are the maxillary sinus ostia are rarely visualised in the depths of the ethmoid infundibulum, and any view of the frontal sinus ostium will depend on the superior insertion of the uncinate process.

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- 1 Havas TE, Motbey JA, Gullane PJ. Prevalence of incidental abnormalities on computed tomographic scans of the paranasal sinuses. *Arch Otolaryngol Head Neck Surg* 1988;114:856-9.

Vitamin A supplementation in preschool children with acute diarrhoea

EDITOR,—Nita Bhandari and colleagues report the results of a trial of vitamin A in the prevention of respiratory and diarrhoeal morbidity in a population of children likely to be clinically or subclinically deficient in vitamin A.¹ We do not believe that the conclusions are justified by the results described, and the public health implications contained in the box are misleading.

The first two points in the box are not contentious and are based on previous research. The third point, referring to the authors' study, states that in children aged 1-5 vitamin A supplementation reduces the prevalence of diarrhoea associated with fever by 36%. This finding applies only to those aged 23 months and over, thus excluding some children aged 1 year, and was based on subgroup analysis of the data. The P value for this observation was only 0.05, and given that 20 subgroup analyses were carried out, we do not believe that this can be considered to be significant. The fourth point in the box is that children given supplements suffered less measles. This finding was not significant for the whole study population, and the significant reduction in the younger age group was countered by an opposite (and not similar as stated in the text) trend in the older age group. The main findings of this study are not emphasised in the box—that is, there was no difference in the incidence or prevalence of diarrhoea or respiratory infections between the treatment and control groups.

In the final paragraph the authors recommend that vitamin A supplementation should be provided to children aged 6 months to 5 years in settings in

which vitamin A deficiency is a public health problem. Given that this conclusion could not be drawn from the results of this study and depends on the results of previous trials, an important ethical question arises. The study was carried out on a subgroup of children, many of whom were likely to have subclinical vitamin A deficiency; given the conclusion derived from literature that predated this study, it might be considered unethical to withhold vitamin A in these circumstances. Because vitamin A may be harmful it might be argued that a trial is justified, but a different trial design would have to be used to have sufficient power to detect adverse effects.

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- 1 Bhandari N, Bhan MK, Sazawal S. Impact of massive dose of vitamin A given to preschool children with acute diarrhoea on subsequent respiratory and diarrhoeal morbidity. *BMJ* 1994;309:1404-7. (26 November.)

Authors' reply

EDITOR,—Several of the issues raised by Paul Pharoah and colleagues are pertinent. The reduction in the prevalence of diarrhoea with fever and the incidence of measles was observed only in subgroup analysis and must be considered to be only suggestive. As there was a significant interaction of age on the effect of vitamin A and diarrhoeal morbidity, in this instance analysis within age subgroups was justified and, in a way, more meaningful than the overall analysis.

Several recent publications have reported the impact of vitamin A supplementation on morbidity. The findings ranged from no reduction in children given supplementation in Haiti¹ through a decrease in visits by a doctor because of diarrhoea in Ghana² to an overall reduction in the incidence of diarrhoea by 20% in Brazil.³ In the last study in Brazil the benefit of supplementation was greater for severe episodes of diarrhoea. When diarrhoea was defined as the passage of three or more liquid stools a day the overall reduction in the prevalence of diarrhoea was 8%; the reduction increased to 20% when a more stringent definition of six or more liquid stools a day was used. The variable results reported may be related to the differences in severity of vitamin A deficiency across studies and the different methods of analysis.

When these studies are viewed together vitamin A supplementation seems to reduce the incidence of measles and to affect the severity of diarrhoea favourably but to have no impact on pneumonia. This is consistent with findings on cause specific mortality after vitamin A supplementation in the few studies providing such data.⁴

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- 1 Stansfield SK, Louis MP, Lerebours G, Augustin A. Vitamin A supplementation and increased prevalence of childhood diarrhoea and acute respiratory infections. *Lancet* 1993;342: 578-82.
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- 3 Barreto ML, Santos LMP, Assis AMO, Araújo MPN, Farenzena GG, Santos PAB, et al. Effect of vitamin A supplementation on diarrhoea and acute lower-respiratory-tract infections in young children in Brazil. *Lancet* 1994;344:228-31.

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Carrier testing in children for cystic fibrosis

EDITOR,—Your recent article debating screening for carriers of cystic fibrosis raises important issues.¹ One aspect, however, that has received relatively little attention is whether it is justified to test for carrier status in siblings of patients with cystic fibrosis during childhood. A recent report from the Clinical Genetics Society (UK) was not in favour of testing children for recessive disorders where this is of purely reproductive significance to that child in the future.²

However, we found that 90% (103/114) of parents of patients with cystic fibrosis wanted to know the carrier status of their other children; furthermore, 91% (104/114) believed that they had a fundamental right to know.³ In contrast, we found that most clinical geneticists would try to dissuade the parents or postpone testing until the child was older; 41% (11/27) thought that the parents had no rights to all to know their children's carrier status. Out of 78 doctors working in child health for their views, we found that 76% (59/78) would want to know and 69% (54/78) thought that it was their right to know.

Clearly there is a divergence of opinion, and a consensus probably cannot be reached. As with many difficult ethical issues in clinical paediatrics, the problem of who should make these sorts of decisions remains. Should it be the experts (clinical geneticists), the clinicians who regularly see the families (paediatricians and general practitioners), or the families themselves once properly informed? While it may be prudent to wait until the siblings are old enough to express an opinion, problems may arise when parents of younger children are insistent as carrier testing is becoming more readily available. Commercial pressures will eventually make such testing available both in private laboratories and from local chemists, and the worry is that results will not be accompanied by adequate genetic counselling.

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- 1 Raeburn JA, Marteau T. Screening for carriers of cystic fibrosis. *BMJ* 1994;309:1428-30. (26 November.)
- 2 Clinical Genetics Society (UK). The genetic testing of children. Report of a working party of the Clinical Genetics Society (UK). *J Med Genet* 1994;31:785-97.
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Management of childhood nephrotic syndrome

EDITOR,—P D Mason and C D Pusey's review article on diagnosing and treating glomerulonephritis does not refer, in the paragraph on minimal change nephropathy in children, to the recently published consensus statement of the British Association for Paediatric Nephrology on the management of steroid responsive nephrotic syndrome.^{1,2} In particular, Mason and Pusey's recommendations on treatment differ from those of paediatric nephrologists.

It is inaccurate to state that the use of alkylating