is unfounded and, on average, test weighing gives a result insignificantly different from the true value.

The fact that the slope is rather shallow, although not significant, is of interest; however, it may well be related to the poor accuracy of the scales used. A repeat of the study using an electronic balance ought to lead to a slope appreciably nearer unity.

Dr Whitfield and co-workers comment:

It is clear that the accuracy of the weighing procedure could be considerably improved by using an electronic balance to record baby weight. However, as mentioned on page 920 of the paper the purpose of the study was to investigate 'routine test weighing in the clinical context, rather than as an optimal research procedure'.

The regression analysis undertaken considered the prediction of 'exact' FW from measurement on TW. Information on FW was required given an observed TW; this was the appropriate direction of the regression equation from a practical standpoint. It was not necessary that the independent variable be measured without error when the analysis was to be considered as predicting a measurement Y conditional on the X as observed. Conclusions were therefore based on the regression of FW on TW and the regression of TW on FW was not considered relevant.

### Timing of neonatal cerebroventricular haemorrhage with ultrasound

Sir,

De Crespigny et al.

The precipitating factors observed to precede periventricular haemorrhage in 90 infants

<table>
<thead>
<tr>
<th>Event</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypercapnia/acidosis</td>
<td>22</td>
</tr>
<tr>
<td>Preterminal event (multifactorial)</td>
<td>16</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>14</td>
</tr>
<tr>
<td>ETT problem</td>
<td>12</td>
</tr>
<tr>
<td>Birth trauma/asphyxia</td>
<td>12*</td>
</tr>
<tr>
<td>No observed cause</td>
<td>12</td>
</tr>
</tbody>
</table>

*3 not transferred until >12 hours old.

To periventricular haemorrhage (Table). Birth itself could be directly linked to periventricular haemorrhage in the first 12 hours in only 9 infants. Delivery was unmonitored or non-vertex in 7 of them. The other haemorrhages occurring in the first 12 hours were multifactorial preterminal events.

Timing of haemorrhage related to increasing birthweight and maturity in our infants. The mean (±SD) birthweight of infants bleeding before 12 hours was 0.91 ± 0.23 kg, mean gestation 27.5 weeks. In contrast infants bleeding after 48 hours were larger and more mature (1.25 ± 0.4 kg, mean gestation 29k weeks).

In 12 of 38 infants sustaining a grade 3-4* haemorrhage, extension was observed at least 24 hours after the initial bleed. Nine of these infants died, reflecting their underlying severe illness.

We cannot explain the differences in the British results compared with those of de Crespigny but perhaps there were differences in the populations. Perhaps celestial orientation has previously unrecognised effects?

### References


M E I Morgan and R W I Cooke

Liverpool Maternity Hospital,
Oxford Street,
Liverpool L7 7BN

### Munchausen syndrome by proxy and pseudo-epilepsy

Sir,

Since writing the article published earlier this year many more cases have been uncovered in which mothers have
Timing of neonatal cerebroventricular haemorrhage with ultrasound.
M E Morgan and R W Cooke

Arch Dis Child 1982 57: 811
doi: 10.1136/adc.57.10.811-a

Updated information and services can be found at:
http://adc.bmj.com/content/57/10/811.2.citation

Email alerting service

These include:
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/