Selective examinations on starting school

Sir,

I would strongly agree with the call by O'Callaghan and Colver to abolish the routine medical examination at school entry. They describe a system of selective examination and provide some documentation about the process and about findings. Of course to prove conclusively that such a system is better than routinely examining every child at school entry would require a prospective study of some magnitude, but there is nevertheless much anecdotal evidence to support the notion that the routine medical examination at school entry is an outmoded concept that is an inefficient use of time and resources.

In Australia, as well as in England, the routine medical examination at school entry has been a longstanding tradition. It is a superficially attractive concept to examine every child at school entry, giving some children a clean bill of health and detecting problems in others that can be appropriately treated in order to prevent subsequent sequelae. A more critical analysis of this practice, however, raises a number of issues:

1. It is probable that most important problems have already been detected because most children now have access to a regular source of health care.
2. It follows therefore that there is a low yield of abnormalities detected at school entry that are both new findings and are important in terms of the child's ongoing health and school performance.
3. The natural history of some of the conditions detected (for example, serous otitis media) is such that there does not exist an intervention which is widely accepted and which is known to make a difference to outcome.
4. Detection of problems does not necessarily result in appropriate treatment or management, because there is usually a reliance on compliance of parents for ongoing referral, etc.
5. There is overwhelming evidence that important problems at school have to do with the sequelae of chronic illness as well as developmental, behavioural, and psychosocial issues, rather than the sorts of findings detected by a routine physical examination.

A recent Australian study concluded that abolishing the school entry examination would allow a 'redistribution of existing resources in order to concentrate more on ensuring effective management of identified problems'.

There are many methodologies that could be implemented if resources were freed from school entry examinations and applied to the assessment and management of children in need. Callaghan and Colver have described one that obviously works in their school district, and it is inevitable that the needs of school children are better served by such a system than by routine examinations. The authors also argue against routine neurodevelopmental examinations at school entry—I would concur strongly with this as well.

It would seem a more productive use of time to confine such detailed assessments to the small group of children who present with difficulties of learning or behaviour rather than to administer such examinations routinely.

References


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Enuresis in children

Sir,

The personal account of enuresis by a 16 year old girl is a reminder that many areas in the United Kingdom lack special facilities for dealing with this common and distressing condition. Management of enuresis requires specific treatment for the symptom and also help for family difficulties, which were evidently present here. Most children with wetting problems have a poor self image, which needs to be bolstered. If a child is referred for diurnal enuresis I ask the head teacher if someone will take him or her regularly to the toilet in a friendly discreet way. The mother is asked to do the same at home. With
old children this is combined with bladder training exercises. Involvement of school staff leads to a supportive atmosphere and, with girls in particular, classmates of their own accord often become helpers too. Most children do well but, if not, urological abnormality or emotional disorder needs to be considered.

In the case of bed wetting, 10–20% of children respond completely to simple supportive measures directed towards relieving them of their fear of waking up wet. For those that do not respond use of an enuresis alarm is the most effective treatment. It need cause no emotional trauma, and it arrests bed wetting in over 80% of cases. Proper supervision is, however, essential; regular clinic visits give opportunities for counselling and for involving the social services, if necessary. The ready availability of psychiatric advice is indispensable in view of the incidence of emotional difficulties in children with enuresis.

Cure of this girl’s enuresis may not have been easy, but I believe that much of her unhappiness could have been avoided by wiser management and by advice to her teachers.

References


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A ‘new’ manoeuvre for removing foreign bodies from the nose

Sir,

I was impressed by the simplicity of a manoeuvre, described by Guazzo, for the removal of foreign bodies in the nose, and I was determined to attempt the procedure when the opportunity next arose. Only weeks after I had read the letter my 3 year old daughter dutifully obliged by inserting a plastic bead deep into her nostril.

The method is as follows: an explanation of the procedure is given to the child, age permitting. The patient’s unobstructed nostril is gently closed with finger pressure, a guaze swab is applied to the doctor’s mouth, which is then opposed to that of the patient. The doctor exhales through the patient’s mouth until resistance is felt—this is the epiglottis closing. Once this resistance has been perceived the doctor exhales briskly, providing outward air pressure; this moves the foreign body towards the exterior where it can be easily grasped with forceps. Often the foreign body will actually fly out unaided. The nostrils should be examined afterwards to determine that no further foreign bodies remain and the parent instructed to return should a bloody or offensive nasal discharge develop.

Since deciding to attempt the manoeuvre I have treated several patients. In each case the foreign body was removed in its entirety, with no evidence of trauma on examination of the nares afterwards, and with no further complications.

The biggest advantage of the manoeuvre is that practically no instrumentation is required. This avoids iatrogenic trauma, and especially in the hands of the inexperienced, the problem of inadvertently pushing the foreign body deeper into the nostril on attempted removal.

Reference


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S Dischie

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http://adc.bmj.com/content/63/2/225.2.citation

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