would be indicated for further investigation or increased enzyme dosage by the microscopy method. The authors' enthusiasm for the test is therefore not warranted and it would not, as was suggested, identify the non-compliant for there would be no way of differentiating the latter from a poor responder. Those who spend their working days contemplating stools understand the need for an alternative to the 72 hours fat excretion test. The 'bluebird' still eludes us.

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Clinical monitoring of steatorrhoea in cystic fibrosis

Sir,—Walters and colleagues, comparing methods of assessing steatorrhoea in cystic fibrosis, attributed the steatorrhea test to Colombo.2 The correct attribution is Phuapradit3 and so their claim to have used the method 'exactly as originally described' is not substantiated.

Phuapradit et al published the steatorrhea as a method for assessing fat excretion in the newborn. If applied to the older child on a mixed diet, particularly if the subject is malabsorbing (the authors did not say whether or not these subjects were receiving pancreatic enzyme supplements during the study), the stool homogenisation technique becomes crucial. A fine tolerance Potter-Evichem homogeniser is essential for satisfactory dispersal of stool solids and the homogenate water content must be higher than that used by Phuapradit and colleagues. Once extracted, the conditions for homogenisation and centrifugation must be scrupulously observed. Walters et al thought them insufficiently important to give details of either step and it is not surprising therefore that serious technical difficulties were experienced. The steatorrhea cannot be dismissed on this evidence.

The other semiqualitative stool fat method assessed was microscopy of stool homogenate, after lipid staining (a subjective assessment but apparently not done blind). It produced a specificity of 55% or 64% depending on which of the two normal fat excretion limits quoted is accepted (20 mmol/day in the text, 17.5 mmol/day in figs 1 and 2). Most children with cystic fibrosis achieve normal or near normal fat excretion when given microencapsulated enzyme supplements but half such children exclude severe steatorrhea but neither this indirect method, nor any other presently available, will quantify the severity of fat loss and we would certainly not make this claim.

Patients who do not come

Sir,—Stamps are cheaper than visits. Instead of a further appointment, mothers can often be invited to write with news of the child, most effectively on an easily remembered such as a birthday, half term, or Guy Fawkes, but at any time if there is concern. An addressed envelope, perhaps stamped, should remain a reminder. The least literate letters are often the most informative, and no news is good news. The letter of thanks from the doctor, not a functioning, can offer another appointment if necessary.

New patients who fail to come can be invited the next week by a personal letter asking them to confirm the booking by telephone, so that it may be offered to another child if necessary. If there is no response, the referring doctor is told.

Paediatricians rarely have unplanned waiting lists for admission, but it is worth telephoning to ask if a proposed date is convenient before sending it.

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Monitoring and sudden infant death syndrome

Sir,—We are disappointed with your recent article on home monitoring and sudden infant death syndrome.1 On average between five and 10 infants at risk of sudden death are referred each week to our department by their consultant paediatrician or family practitioner for investigation and management. The latter includes a home monitoring programme that involves the use of transcutaneous oxygen pressure (PO2) monitors and this is well known to the Foundation for the Study of Infant Death and to the other authors of your article. We have presented our results at international (paper presented at joint meeting of British Paediatric Respiratory Group and Foundation for Study of Infant Death, Liverpool 16 September 1988) and international2 conferences concerning sudden infant death. The single 'to the contrary' sentence in the article dismissing transcutaneous PO2 monitoring in the home is not based on experience but on prejudice following its use in neonatal units. In contrast, we have experience in over 250 infants with the use of this monitor in the home for periods up to 13 months (mean (SD) 6.4 (2.6) months). Unlike breathing movement detectors, this monitor is 100% sensitive to hypoxaeic episodes. It has infrequent false alarms (one every six days) compared with an average of six per day for monitors based on impedance pneumography and electrocardiography.3

In our experience, the PO2 monitor does not cause skin burns (sensor temperature 43°C, recommended resting interval eight hours), has a median response time of 21
Clinical monitoring of steatorrhoea in cystic fibrosis.

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