index terms for searching MEDLINE on computer databases and the vagaries of the library catalogue. My colleagues and I are, in fact, slowly adapting ourselves to the fact that what we have been doing is storing and retrieving things—books, journals, papers, etc., while what our customers often want is not things, but information. Up till now, however, much of the revolution which is leading to the 'death of the book' and the end of the scientific journal, has consisted of books and journal articles. I wonder if there is any evidence of Caxton or Gutenberg circulating illuminated manuscripts on 'the death of the illuminated manuscript' during the last century? I also wonder if I would have come across Dr Clayden's opinions if he had circulated them by electronic mail rather than in the form of a journal article.

More seriously, a cause for concern is the common delusion among doctors that because information is going to become available in an electronic form it is somehow going to be 'free'. A quick glance at the organisations currently involved should convince them that this is not the case—DIALOG, which is a subsidiary of the Lockheed Corporation, Pergamon Press, EM-BASE which is owned by Elsevier, and DATA-STAR which is owned by the Swiss Radio Corporation. It seems to me to be much more likely that those hospitals and medical schools which can make a major financial commitment to information systems will end up being much better served than they are at present, but that isolated specialists working in poorer parts of this country, let alone those in Bulgaria or Bangladesh, are going to be considerably more deprived of information than they are at present. Much of the technology already exists, but we do not have the staff to offer it. Brophy tells of a new polytechnic lecturer who had arrived from a commercial research organisation in which he had a personalised publication bulletin every Monday, with all the documents he ticked in it delivered to his desk by Friday, and a regular visit from his information officer to make sure the document supply was on target. The polytechnic had the technology to do the same, but it had an average of one subject librarian to 1100 readers, and is very unlikely to make the investment in people, as well as in equipment, necessary to take advantage of the technology.

One thing which puzzled me was Dr Clayden's implicit assumption that he is going to retain his functions, and even his title, during the upheaval he predicts. The 'death of the book' surely implies the abolition of the 'reader in paediatics'. Even if he changes his title to that of the less euphonious 'VDU-scanner in paediatrics' it seems to me to be much more likely that I will be able to stagger on as a sort of glorified juke-box attendant, but that many of Dr Clayden's functions can be taken over by an Expert System, on the one hand, and by far fewer paid counsellors on the other. I hope and expect that he and I will get safely through to retirement all right, but I have doubts about our successors.

Squatting and urinary tract infection

Stir—I read with interest the article by Hellström et al on the association of urinary symptoms and previous urinary tract infection.1 Hellström et al found urinary tract infection in 15 (37%) of 41 children with squatting. We agree that urinary tract infection is common in children with squatting.2 In the past 22 months we identified 16 children who presented with squatting at least once per week. The average age at our assessment was 77 months, range 47 to 126 months. There were 15 girls and one boy. The table shows the frequency of chronically holding the urine to the last minute and urinary tract infection in these children. None of the children had enuresis, a gait disturbance, a palpable defect in the lumbar spine, or an abnormal neurological examination.

Nine of the 16 children had undergone an Expert System with no satisfactory result. Two children had mild vesicoureteric reflux, two had trabeculated bladder (one also had a bladder diverticulum), and one had urethral stenosis. Only two children had normal results on these studies and both of these children had a history of chronically holding the urine to the last minute. Four of the five children who did not hold their urine to the last minute had abnormal results on the studies.

fibrosis patients using intraoesophageal pH monitoring is not well tolerated by patients with cystic fibrosis with established pulmonary disease, this is an area which merits further study.

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Paracetamol suppositories after cardiac surgery

Sir,—We read with interest the article by Hopkins, Underhill, and Booker concerning rectal absorption of paracetamol.1 We have performed a similar study on 20 children, mean age 3-75 years (range 0-28-10-58 years), giving paracetamol suppositories (Macartneys Laboratories Ltd) when they became feverish, four to six hours after the cessation of cardiopulmonary bypass (11-14 mg/kg body weight). Rectal temperature was monitored continually and plasma paracetamol concentrations were measured every hour for four hours.

The minimum therapeutic plasma paracetamol concentration for an antipyretic effect is 66 μmol/L.2 In 18 of our 20 patients the paracetamol concentration never exceeded 25 μmol/L (the lower limit of detection in our assay) and reached only 35 and 29 μmol/L (at two hours) in the remaining two patients. In 10, K-Y Lubricating Jelly (Johnson and Johnson) was used to aid insertion of the suppositories, but this did not effect absorption. There was no fall in rectal temperature over the four hour period.

We analysed the batch of suppositories and found an acceptable 92% bioavailability. As doses of 10 mg/kg have been shown to reduce temperature in preoperative children,3 we suggest that the poor absorption must be due to patient factors, such as an ileus or interference from anaesthetic drugs. The study by Hopkins et al would support this.4 Although similar doses were used, the plasma paracetamol concentrations were higher (albeit subtherapeutic). As the suppositories were given much later (24 hours after operation), it suggests that the effects of some drug or unknown factor could be wearing off. It would be interesting to re-examine these patients one week later. Whether poor rectal absorption is specific to cardiac surgery and whether other drugs are similarly affected, is uncertain, but needs careful evaluation.

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