the infant with diarrhoea and failure to thrive whom we wish to investigate. As pancreatic insufficiency is relatively rare compared with other causes of this presentation, an investigation with high specificity is essential. As the authors have yet to produce any data on this crucial aspect of their test, may I recommend a simple, cheap, sensitive, specific, and repeatable alternative to this test. These patients are generally only too happy to provide specimens — faecal chymotrypsin measurement. The dual marker pancreolauryl test is promising but needs further evaluation; I hope it has not been prematurely discarded.

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Epilepsy in children and the risk of drowning

EDITOR,—Dr Kemp and Sibert raised the issue of death by drowning in children with epilepsy.1

We recently had a patient aged 10 years who had had epilepsy for four years and who was on treatment with sodium valproate. He had initially presented with frequent absences and these lasted only for a few seconds at a time. He had no other neurological problems. Before his death he had had no fits for the previous three weeks and had never had any generalised tonic-clonic seizures. He was found by his parents drowned in his bath having been in the bath for 5–10 minute period; he was resuscitated and was admitted to this hospital to the intensive care unit. On admission he was comatose, his pupils were fixed and dilated. He was treated by intermittent positive pressure ventilation, fluid restriction, and anticonvulsants. He developed further seizures the next morning, associated with hyperthermia and hypertension, and died 14 hours after the initial drowning episode. Postmortem examination showed presence of cerebral oedema and a few anoxic changes within his brain.

His history is a little similar to subject 1 in Kemp and Sibert’s paper, that is, a child with normal intellect and no neurological signs who had only a fairly minor form of epilepsy and no major motor problems. His death underlines the importance of supervision in the situation where drowning is a potential problem. All these cases support the view that all parents who have children, even if they have minor seizures, must either arrange for supervision of their children while they are in the bath or as suggested by Kemp and Sibert use a shower in an unlocked room.

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Injury epidemiology: emerging statistics and strategy

EDITOR,—Recent articles in this journal are not only in tune with the World Health Organisation (WHO) message of the year ‘handle life with care; prevent violence and negligence’, but also have added significance to forward-looking readers.1,2 International trends in pedestrian injury mortality support the view that strategies directed towards upgrading the environment pay more dividends than educational awareness programmes.3 However such conclusions may unwittingly convey to developing countries that these strategies are mutually exclusive. For instance, in a symposium on injury prevention and social responsibility organised in this institute on WHO day, the delegates were equivocal in their emphasis on the environment and education. We think that these approaches are interdependent and reflect the dynamics of socioeconomic and political processes of a particular society. Improvements in the environment cannot come about without society demanding it, and this later phenomenon of peoples’ assertion is unlikely to come from populations who lack awareness and education.

In the epidemiology of injury the conventional classification of children’s mortality statistics into an age group 5 to 14 years fails to differentiate and delineate the prevention and management of children of different ages correctly. The majority of children who are aged less than 9 and those who are older. Instead, for the epidemiology of injury children should be subdivided into 5–9 and 10–14 year age groups. This would provide the particular age group educational strategies and environmental changes play a major part compared with education aimed at modifying the behaviour of children. This latter strategy impinges upon the normal development of children by suppressing epidemiological understanding of age related problems and facilitate effective interventions in the hazardous host-agent-environment relationship. For example, children under the age of about 9 years do not have the necessary perceptual abilities to assess all the sensory inputs of the accident scenario such as traffic signals, etc., and hence they are unable to make a quick decision to avoid the accident. For this particular age group educational strategies and environmental changes play a major part compared with education aimed at modifying the behaviour of children. This latter strategy impinges upon the normal development of children by suppressing epidemiological understanding and curiosity for exploring their environment. On the other hand children older than 9 may benefit from educational programmes to boost the effects of environmental measures.

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Pressure reduction of intussusception

EDITOR,—In this January’s issue of the journal you published a paper from this centre.
Epilepsy in children and the risk of drowning.

M Reid

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