temperature. We suggest that mode of feeding be added to the list of factors being investigated with regard to increased heat production.

Differences between breast fed and formula fed infants in metabolic rate, which is directly related to heat production, have already been reported, and we have recently found higher metabolic rate to be significantly higher in formula fed compared with breast fed infants at age 12 weeks. Furthermore, total daily energy expenditure (TDEE) measured by isotopic methods has also been shown to be significantly greater in formula fed than breast fed infants. In a longitudinal study in the first year of life, TDEE was found to be significantly greater in formula fed infants at 6 weeks and 12 weeks of age. An increased energy intake between the diet groups at 6 months and 9 months (P S W Davies, unpublished data). This pattern correlates with the reported distribution of SIDS by age.2

A number of studies of SIDS have reported higher rates of formula feeding in cases compared with controls.4 Because SIDS does occur in breast fed infants, formula feeding has not been considered a major risk factor. Some authors have suggested that the relationship between formula feeding and SIDS incidence is an artefact of the relationship between SIDS and social class. However, it is also possible that the reverse is true, and that variables such as family size, social class, maternal age and interpregnancy gap are related to SIDS incidence because of their effect on aspects of infant care, of which formula feeding might be one.

If this hypothesis is correct, one explanation might be that the amount of energy in contemporary formula is high in comparison to breast milk. This view has been increasingly supported from recent studies of nutrition, growth, morbidity, and development of breast and formula fed infants. These findings support the need for a thorough review of energy requirements in infancy and especially the adequacy of the energy density of infant formulas.

The physician's hands and early detection of neuroblastoma

EDITOR—The data from some developed countries show that within the past 25 years, the five year survival rates in neuroblastoma have increased twofold from the initial 25%. The outlook for patients presenting over 1 year of age with stage IV remains dismal (20% five year survival). The drop in mortality rates is related to more frequent detection of neuroblastoma in early infancy, but before their disease is advanced as well as more frequent incidental detection of the neoplasm.2,4 (see also Carlsen for further references).

In the years 1943–80 in Denmark, the percentage of incidentally detected neuroblastoma increased from zero to 14%. Among children with incidentally detected neuroblastoma, stages I and II predominated (16% of total). Only 5% of children treated for neuroblastoma was 250, and nearly one half of all 53 long term survivors were found incidentally or had 'spontaneously regressing' tumours.6 In Germany, the frequency of medially examined children, especially below 1 year of age, during obligatory check up visit to almost 90% of parents faithfully reported, allowed the incidental detection of neuroblastoma in every sixth patient with this tumour. Out of 65 children at stage I and 60 patients at stage II, incidental detection of neuroblastoma occurred, respectively, in almost every second and third patient with this disease.7 This may suggest that a systematic approach,8 a greater awareness of the relatively high incidence of this tumour (the most common solid tumour in children), and the need for good abdominal examination may increase the detection of children with neuroblastoma before the onset of symptoms.9,10 The shift to diagnosis at earlier ages and stages may result from more frequent chest radiographs and use of ultrasonography of the abdomen. Sawada et al found that even a small abdominal tumour of neuroblastoma can be detected by careful examination. Out of 293 infants suspected of neuroblastoma on the basis of urinary screening, physical examination revealed a tumour in more than one half of the patients. A careful abdominal examination is of a great importance in neuroblastoma (the primary tumour is in 75–95% of the cases located within the abdomen).

The hands and eyes of a physician have always been and continue to be the most important tools in detecting diseases. A physician may notice slight, rare symptoms of low stages, such as the total number of a neuroblastoma, such as Horner's syndrome and associated heterochromia, the watery diar-

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2 Sankila R, Hakama M. Survival trends for neu-


SPRING BOOKS


At last—a book about my craft which I can identify with and recommend to trainees and others who may be wondering what we actually do. For me this book fills a gap, as it explains why psychiatrists train, challenging those textbooks that have focused on describing the various conditions or predicaments which we deal with as child and adolescent psychiatrists. The aim of this book is to help paediatricians and other doctors address the psychiatric aspects of children's health problems. The editor, Professor Elena Garralda, adds that she hopes this book will be of interest to not only doctors but also teachers, social workers, and to our own psychiatric trainees. She also hopes that the book will help in the referral of disturbed children to specialist services. The contributions have all been reprinted from the series in the Archives entitled 'Types of Psychiatric Treatment', and which ran for 14 issues.

The first two contributions deal with the identification of psychiatric disorders in children followed by a brief overview of the types of available psychiatric treatment, as well as the all important question of efficacy. The remainder of the book then amplifies the types of treatment and management approaches which we use. I cannot pick out one or two chapters for special mention, which is an indication of the high level of each of the
The physician's hands and early detection of neuroblastoma.

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