It seems unwise to assume the haemoglobin concentrations reported by Emond et al are lower than those that would have been observed before the disease was diagnosed in the children. Their method of sampling appears to be similar to our own, and given the bias to slightly higher values obtained with the Haemocon (assuming the values given by the laboratory analyser represent truth), it is possible that venous haemoglobin values in their population could be on average some 5 g/l lower than those reported for skin puncture samples.

Dallman PR, Reeves Moe J, 35
in 1971


Coburn TJ, Miller WV, Parrish WD. Unacceptable variability of haemoglobin estimation on samples obtained from ear punctures. Transfu-


Challenges in the management of childhood brain tumour

EDTORS.—A number of major challenges need to be faced if the outcome for children with brain tumours is to improve. Primary and secondary care physicians need to have a greater awareness of the symptoms and clini-
cal signs that justify the urgent referral of children with tumours of the central nervous system and special arrangements for han-
dling such referrals need to be negotiated. Families need improved access to information at the time of diagnosis so that they can learn about the full range of available therapeutic options.

It is mandatory that a national network of specialist neuro-oncology teams should be developed to which children would be selectively referred. Clearly such referrals should take place before any surgical inter-
vention is undertaken. This may mean that individual neurosurgeons have to accept that they cannot operate on children with brain tumours if they are not able or prepared to manage the child within an appropriate multidisciplinary team. Such teams should be patient, not specialist, centred and would develop strong links with local community paediatric services. Such a change in attitude may need the combined intervention of health professionals and parents, the latter using the rights for special needs education prescribed by the Children Act as a basis for their lobbying.

The United Kingdom Children's Cancer Study Group (UKCCSG) has made consid-
erable progress in developing audited, col-
laborative research protocols that will allow assessment of the relative merits of different treat-
ments. There is a need for ever closer neurosurgical input into clinical trial develop-
ment.

Such a reorganisation of facilities for child-
hood brain would be greatly assisted by the development of specialist purchasing guide-
lines that define core standards of care. This process has been discussed by representa-
tives of the paediatric neurological and oncologi-
cal interest groups of the UKCCSG. Ap-
proval of all the relevant royal colleges is being sought.

We hope that we can ensure more consist-
tent service provision for UK children with brain tumours. Current inequalities in health service availability become too obvious when high profile cases seeking international referral hit the national headlines.

DAVID A WALKER
(Chairman UKCCSG Brain Tumour Committee)
Department of Child Health, University of Nottingham, Floor E, East Block, Queen's Medical Centre, Nottingham NG7 2EH

ANTONY J MICHALSKI
(UKCCSG Brain Tumour Committee Member)
Department of Haematology and Oncology, Great Ormond Street Hospital for Children NHS Trust, Great Ormond Street, London WC1N 3JH

The controversy over the use of bicarbo-
nate was clearly mentioned in the second part of our paragraph on asystole, and although results were included they did not affect overall figures for sequence failure. With regard to the use of a precordial thump—this has similar connotations to bicarbonate usage and in the scenario that we gave would be either not required or undesirable.


Sleeping position and cot death

EDTORS.—The trend of the incidence of the sudden infant death syndrome (SIDS) in Austria 1 strikingly resembles the one pre-
sented by Gilbert from England and Wales 2 (see figure 1). However, in our opinion there are several arguments against the widespread assumption of a causal relationship between the prone sleeping position and SIDS.

Firstly, it was at the 13th International Paediatric Congress in Vienna in 1971 that the assumed advantages of the prone sleeping position were first presented by the Austrian paediatricians Reisertbauer and Czermak. 3 If the prone sleeping position were to be blamed for the growing occurrence of SIDS, problems encountered. The controversy over the use of bicarbonate—this has similar connotations to bicarbonate usage and in the scenario that we gave would be either not required or undesirable. We hope that we can ensure more consistent service provision for UK children with brain tumours. Current inequalities in health service availability become too obvious when high profile cases seeking international referral hit the national headlines.

Table 1 Mean haemoglobin concentrations in paired venous and skin puncture blood samples

<table>
<thead>
<tr>
<th>Haemoglobin range in venous blood (g/l)</th>
<th>Mean (SD) skin puncture haemoglobin (g/l)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 90 (n=42)</td>
<td>84.1 (13.2)</td>
<td>p &lt; 0.0001</td>
</tr>
<tr>
<td>91-110 (n=94)</td>
<td>104.8 (7.5)</td>
<td>p &lt; 0.0001</td>
</tr>
<tr>
<td>≥ 111 (n=52)</td>
<td>121.4 (8.5)</td>
<td>p &lt; 0.005</td>
</tr>
<tr>
<td>All (n=188)</td>
<td>104.8 (16.1)</td>
<td>p &lt; 0.0001</td>
</tr>
</tbody>
</table>

Mean (SD) venous haemoglobin (g/l) | Mean (SD) skin puncture haemoglobin (g/l)
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>79.5 (10.4)</td>
<td>4.7</td>
</tr>
<tr>
<td>101.2 (5.0)</td>
<td>3.6</td>
</tr>
<tr>
<td>119.1 (6.3)</td>
<td>2.3</td>
</tr>
<tr>
<td>101.3 (15.6)</td>
<td>3.5</td>
</tr>
</tbody>
</table>

CI (g/l) | 7 to 15.1 |
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<tbody>
<tr>
<td>7.7 to 14.9</td>
<td></td>
</tr>
<tr>
<td>8.7 to 13.3</td>
<td></td>
</tr>
<tr>
<td>7.6 to 14.6</td>
<td></td>
</tr>
</tbody>
</table>

Dr Buss comments:

There was a typographical omission from the reference for the APLS guidelines—hence the problem that Dr Ward encountered. The third reference should have ended: London: BMJ Publishing Group, 1993 (reprinted with revisions 1994).

The study itself used the current guidelines at the time (1994), and we stressed in our second paragraph that the 'Guidelines for paediatric resuscitation published by the European Resuscitation Council (1994) are incorporated within the advanced paediatric life support protocols'. This directly infers that we were using the 1994 APLS protocols but the failure to indicate this accurately in the references was not picked up by ourselves or the referees and Dr Ward is to be congratulated for noticing this incongruity.

Because of the experience of such a protocol the report was modified on the previous day to be revised for publication. This was an answer to the 'Guidelines for paediatric life support: the practical approach' published by BMJ Publishing Group, 1993.

Figure 1 Mortality from SIDS and postnatalon mortality (PNM) in England and Wales (E/W) and Austria (A).
Challenges in the management of childhood brain tumour.

D A Walker and A J Michalski

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