LETTERS TO THE EDITOR

Neural tube defects and zinc

EDITOR,—I read the article by Bound et al on the involvement of deprivation and environmental lead in neural tube defects (NTDs) in the journal with great interest. The suggestion that lead is a possible cause of NTDs, especially anencephaly, either by direct action or by influencing food intake and folate availability is interesting. The suggestion is not supported by reliable methods to assess the zinc and folate status of the mothers of future cases.

The zinc status of mothers of children born with neural tube defects also needs to be reconsidered. Epidemiological studies have suggested that zinc deficiency is one of the most important factors in the etiology of NTDs. Zinc deficiency is due to chronic zinc deficiency, which results from a decrease in zinc absorption in the small intestine. It has been shown that zinc deficiency leads to an increase in the prevalence of neural tube defects in women with a history of previous anencephalic infants.

In our recent report concerning maternal plasma zinc concentrations after an oral zinc tolerance test in pregnancies associated with NTDs in Turkey, it was shown that the maternal plasma zinc levels were lower in the mothers of children born with NTDs than in the mothers of children born without NTDs.

Integrated management of childhood infections and malnutrition

EDITOR,—The article by Campbell and Gove was timely and excellent. I am working in Bolivia to implement the programme developed by the World Health Organisation (WHO), “Integrated Management of Childhood Illness” (IMCI), as a means to decrease the high mortality of children less than 5 years old due to the most common illnesses in each region by appropriate and integrated management.

The programme has been adapted to the needs of Bolivia and we have already run a workshop, in the participation of paediatricians from all over the country. The Bolivian Health Department is very enthusiastic to start the IMCI programme as soon as possible and is one of the first Latin American countries adopting it.

The main paediatric health problems in Bolivia are respiratory infections, diarrhoeal diseases, tuberculosis, malnutrition, anaemia, malaria, and infections in the newborn period.

Head lice in schoolchildren

EDITOR,—In his recent letter, Charlton raises concern that head lice can be transmitted on combs and brushes. We agree. This is so in certain circumstances: healthy lice, forcibly removed from the head will re-establish if they are allowed back on a head within one or two days of removal. Lice can be caught on a comb or brush and returned to the head at another time. Lice can be brought to school by children who have not washed their hair for some days and who carry live lice. Combing dry hair can propel lice by electrostatic charge through the air. If they land unnoticed on a person’s clothing or skin they will climb up to the head.

Thoroughly wet lice, however, appear dead and remain motionless until they dry off, which takes some time especially if they are bathed in ordinary hair conditioner; this provides ample time to remove them from a comb and dispose of them before they reactivate. The “bug busting” method discussed in our review is entirely performed in wet hair and the carer is instructed to examine the comb for lice and remove the lice from each tooth. This can usually be done by wiping on kitchen paper or rinsing; if any lice lodge between the teeth, a cocktail stick or nailbrush will ease them out. A white plastic cap is provided in the Bug Buster Kit to protect the patient and because any lice landing there can be easily wiped off. We agree that the education of hairdressers in these facts is important.

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Correction

Development of a paediatric coma scale in intensive care clinical practice

Unfortunately an authors’ error occurred in the above paper by Tatman et al (Arch Dis Child 1997;77:519–21). In table 1 under the heading “Motor”, M6 should read: “obeys commands . . . normal spontaneous movements” and M5 should read: “localises to pain stimulus . . . as older child or withdraws to touch”.

BOOK REVIEWS


In the six years since the publication of the first edition of this report it is unlikely that many of the abnormalities have become truly comfortable when faced with the request to provide a medical opinion as to whether a child has been sexually abused. However, much has been learnt which if not allowing us to feel comfortable should at least allow us to feel more confident in our attempts to meet the needs of this group of children.

An increasing literature concerned with normal and abnormal findings on examination as well as with examples of good models of practice is reflected in the increase by one third in the size of the report. The number of cited references increases from 38 to 60. It is no surprise that the hitherto with the greatest increase in material cover the subjects of normal anatomy and variants in the appearance of female genitalia together with the size of the hynenal orifice. The inclusion of colour photos from colposcopy, rather than line drawings, gives the reader a far more accurate understanding of many points discussed in the text. Interestingly the working party falls short of positively encouraging the use of the colposcope as an anal dilatation appears to have settled. This edition of the report makes subtle but significant changes in its summary of signs in this respect, suggesting that an increased diameter of dilatation (15 mm rather than 10 mm) should be used as a threshold for suspicion and more importantly emphasising that the finding should be reproducible.

Another area in which the second edition of the report has grown is that of the diagnosis and management of sexually transmitted disease. There is a detailed and comprehen-

sive appendix with more references than the main text. It is likely however that practitioners seeing relatively few cases of sexual abuse outside of specialist centres might better develop arrangements for this complex aspect of assessment and management with their local specialist in gynaecological medicine.

As the working party recommends, an increasing proportion of work in the assessment and management of child sexual abuse is carried out by experienced and well trained individuals. Practitioners of specialist services remains variable so it continues to be important by providing a guide to the examination of children and interpretation of physical signs. It could have been improved by includ-

ing recommendations towards comprehensive textbooks able to supply a broader overview of the other aspects of assessment and care that are so important when helping children who have been sexually abused.

MARK HUNTER
Consultant community paediatrician


There is no doubt that two dimensional echo has revolutionised the practice of paediatric cardiology. It is a safe, painless, portable technique that can be performed by the bed/ cotside. It has largely replaced diagnostic angiography. In North America there are now doctors who will perform percutaneous echocardiografia-
graphers in the UK we tend to be “Jacks of all trades”, I forget the rest of that aphorism. Three luminary American echocardiogra-
phers have produced this fine textbook.

It is the second edition, the first was published in 1990. Have things changed enough since then to justify a new edition?....... Colour flow Doppler has develop-

ed into an essential part of the examination and this alone could justify a major revision, or at least many new pictures and about 50 good quality colour plates are included. New branches of clinical echo work such as fetal and transoesophageal echo, and those largely confined to research (at present) such as three dimensional and intravascular, are included, but these techniques are probably best served by their own texts. The authors have radically changed the chapter on quantitative methods. Interestingly, they state that the need for M mode has been virtually eliminated, which may cause a few waves of apoplexy in the UK, but is probably right.

The core of this book remains two dimensional imaging in congenital heart disease. I would have liked to see more line drawings of abnormalities as these can be very helpful for trainees. There are many excellent echo pictures in this book. A recent observation told me that a good textbook should have figures you wished to copy for lecture slides and this book passes that test easily. It is almost as comprehen-

sive as an atlas, but not quite; there are enough gaps to make it a little frustrating for use as a dip-in text to help an experienced echocardiographer establish a rare diagnosis, for example a pulmonary sling.

There is a comprehensive reference section at the end of each chapter, as is the way of major texts, but I wonder if this is really nec-

essary given the easy access to computer searches which will inevitably be more up to date.

This text is unlikely to be of use to paediatricians. Whether paediatricians should be scanning hearts is much debated. I think they should, but would benefit from this book initially, and probably a video instruction (which is something we try to provide in our region), rather than a comprehensive text such as this.

This book is ideal for new registrars (and perhaps echo technicians) in paediatric cardi-
ology, and I recommend it to them.

M BURCH
Consultant paediatric cardiologist


All paediatricians need to know about inherited metabolic diseases. For most of these conditions, diagnosis depends on the astute- ness of clinicians. Though newborn screening may be extended to other metabolic disorders in the future, current programmes in most parts of the UK only detect phenylketonuria and congenital hypothyroidism. Metabolic diseases can present in a wide variety of ways, involving any system of the body. No subspecialist can completely ignore these conditions but neonatologists and general paediatricians need particularly wide knowledge. Dr Clarke’s book is an excellent introduction for paediatricians in training and will also be valuable to established consultants, as there has been dramatic recent progress in this field.

Conventional textbooks have been struc-
tured around the description of individual inborn errors. Given the number of potential defects and the range of features found in each one, this approach is of limited value to clinicians seeking a diagnosis. Dr Clarke’s “clinical guide” is based on clinical presenta-
tions, suggests appropriate investigations, and describes the commoner metabolic diseases associated with each. It is designed for the general paediatrician and is not intended to be exhaustive. Neurological, dermatological, ophthalmological, dysmorphic, and acute neonatal presenta-
tions are considered, along with acidosis and positive screening tests for phenyl-
ketonuria. Renal presentations (apart from renal tubular acidosis) are omitted, as are many rarer manifestations. More comprehen-
sive diagnostic algorithms have been published by Professor Saudubray in The Metabolic and Molecular Bases of Inherited Disease (7th Ed. Edited by C R Scriver et al; New York: McGraw-Hill, 1995) but these lists, though valuable to the specialist, would be indigestible for most trainees.

Inevitably, a textbook based on clinical presentations does not give such a clear picture of each disorder as more conventional texts—but there are several of these available to complement Dr Clarke’s book. In its 280 pages, the “clinical guide” contains 63 useful tables. Some of these contain information that can be surprisingly hard to find else-
where, such as the lists of pathological and spurious causes of organic aciduria. More flow charts might be helpful (there are only


The paediatric MRCP part I examination has created a new market for the burgeoning industry which has developed around medical postgraduate examinations. These two volumes are the latest offerings to the multiple choice question (MCQ) hungry candidate. Volume 1 is a comprehensive review of systems while volume 2 provides six complete examinations for further practice. The authors have wisely refrained from adding to the myriad of often conflicting MCQ tips available to the bewildered candidate and state their brief as the provision of practice material. The advice proffered on examination technique is standard and uncontroversial.

It is a remarkable feat to have conjured up quite so many obscure questions. However the answers are often short, with little or no explanation, and there is rather too much emphasis on eponyms and obscurities. One may question:

A. whether an earnest politician's urine truly smells fishy (vol 1, p35)
B. the odour of a non-earnest (insincere?) politician's urine
C. the wisdom of inserting jokes into an MCQ book and
D. which of the above is true.

Otherwise the questions are generally well organised and unambiguous, and comparable with those in the specimen paper available from the Royal College of Physicians.

SHAMIMA RAHAMAN
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WESTMINSTER BRIEFING

The following items are from Children & Parliament, autumn 1997. Children & Parliament is an abstracting service based on Hansard and produced by the National Children's Bureau. It covers all parliamentary business affecting children and is available on subscription via the internet. The Children & Parliament web site provides direct links to full text Hansard, government department sites, the sites of the Office for National Statistics, Ofsted, and other relevant organisations. For further details contact Lisa Payne, Editor, Children & Parliament, National Children's Bureau, 8 Walden Street, London EC1V 7QE (tel: +44 (0) 171 843 6000; fax: +44 (0) 278 9512). (The Hansard reference is given in parentheses.)

° The Medical Research Council annual spending on diabetes research is some £3 million and the Department of Health Policy Research Programme spent £272 000 on such research in 1996–97. (14 Oct 97, Col 399.)

° The third part of the Disability Discrimination Act 1995 is to be implemented as soon as is practicable. A government task force is to study issues related to securing disability rights and the setting up of a disability rights commission. (21 Oct 97, Col 605–608.)

° Extra money for schools announced in the budget will amount to £1 billion each year for education and a single sum of £1.3 billion for buildings and equipment to cover the current year and the next four years. The money will be spent on books, equipment, teacher training, measures related to discipline and truancy, class size reductions for 5 to 7 year olds, and building repairs. (15 Oct 97, Col 440–444.)

° Questioned about the right of a general practitioner to refuse to take on a lesbian patient, the Minister of State for Health referred to 1992 General Medical Council guidance condemning discrimination on grounds of age, sex, sexuality, race, colour, beliefs, perceived economic worth, or the likely work load for doctors because of the patient’s clinical condition. (21 Oct 97, Col 202.)

° All local authorities are expected to draw up a plan for preschool education to be implemented from April 1998. Places for all 4 year olds will be available by September 1998. Early education is to be integrated with day care. (16 Oct 97, Col 550–552.)

° The 1976 Adoption Act makes no special provision for adoption by lesbian/gay couples. A similar application may be made only by married couples. Unmarried couples may not apply jointly but one of the pair may do so as an individual. (3 Nov 97, Col 74–75.)

° In 1996–97 government grants for asylum seekers with children amounted to £4.1 million; for adults without children it was £5.6 million, and for children without adults £3 million. (13 Nov 97, Col 652–653, 173–174.)

° The government commissioned a review of safeguards against the abuse of children in care. The resulting Utting report presents “a woeful tale of failure at all levels to provide a secure and decent childhood for some of the most vulnerable children”. Over a third of children in residential care are not being educated. Young children, disabled children, and those with emotional and behavioural problems are most at risk of abuse. The report makes 20 main recommendations to safeguard children. (19 Nov 97, Col 327–338, 585–596.)

° A bill due to have its second reading in February 1998 would require information about lead in pre-1960 paint to be provided...
to people who buy paint stripping equipment and fluids. It would also provide for children under 3 living in older houses to be tested for potential lead poisoning.
(19 Nov 97, Col 343–345.)

- The Department for the Environment, Transport, and the Regions is funding research on the safety of children's journeys to and from school.
(14 Nov 97, 18 Nov 97, Col 696–697, 137–138.)

- A Health Education Authority campaign is aimed at encouraging women of childbearing age to take more folate in order to reduce the risk of neural tube defects.
(26 Nov 97, Col 996–997.)

- In 1996–97 there were 1.7 million lone parents in Great Britain and in February 1997 some 1 020 000 lone parents were receiving income support.
(4 Dec 97, Col 328–329.)

- An April 1997 survey showed that 23% of children aged 0–13 in the back seat of a car were not wearing seat belts; in the front seat 6% were not. In 1988 the corresponding figures were 47% and 9%.
(10 Dec 97, Col 27–28, 29.)

- The government's new Social Exclusion Unit is part of the Economic and Domestic Affairs Secretariat in the Cabinet Office and will, at first, concentrate on truancy and pupil exclusion, homelessness and rough sleepers, and sink housing estates. It is to be set up for two years in the first place.
(8 Dec 97, 9 Dec 97, Col 408–410, 20–22.)

- Some 21% of schoolchildren have special educational needs and 3% have statements of their needs.
(5 Dec 97, Col 580–637.)

- The government has promised £200 000 to the United Nations to help the UN special representative on children and armed conflict to start work.
(10 Dec 97, Col 1000.)
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