to be correct. The intestinal transit time of newborn infants is short enough to make 3 days a satisfactory period to establish equilibrium. Furthermore, our experimental design took account of this possibility in that half the babies were fed one milk first and the remainder in the reverse order. Cow and Gate V-formula produced more steatorrhoea when given before or after SMA Ready-to-feed formula.

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Peripheral gangrene in hypernatraemic dehydration of infancy

Sir,

In their article (*Archives*, 1975, 50, 616) on peripheral gangrene in hypernatraemic dehydration of infancy, Drs. Comay and Karabus state, 'Therapy . . . should be directed primarily towards eliminating the cause', and suggest 'treatment of dehydration'. Surely the cause is the dehydration, and elimination of this cause by preventing dehydration occurring would be a more effective form of therapy. Drs. Comay and Karabus state that 36 000 dehydrated children were admitted to their hospital over a 3-year period, and this can only mean that the standard of primary medical care and child health services around their hospital are very poor. If they wish to eliminate peripheral gangrene in hypernatraemic dehydration of infancy, should they not start by raising the standards of service which is being offered in their community?

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Congenital myotonic dystrophy

Sir,

The articles on congenital myotonic dystrophy by Harper (1975) and by Simpson (1975) describe many interesting signs of this disease. However, they fail to mention whether thin ribs were observed on chest x-rays. We (Fried *et al.*, 1975) have found thin ribs as a very helpful sign in the diagnosis of neonatal myotonic dystrophy but more data are needed. In Simpson's case 'Chest x-ray showed normal lung fields', and in Harper's report 33 cases had 'respiratory problems' in the neonatal period. It is hoped that at least some of the original chest x-ray films are still available and will be published in order to get some estimate on the frequency of thin ribs in neonatal myotonic dystrophy. Furthermore, in those patients who survived the neonatal period and had this sign, we may learn at what age this sign disappears.

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Dr. P. S. Harper comments:

Thin ribs were neither observed nor reported on in chest radiography of patients in the series, but the sign was not specifically sought and the films will be reviewed. Dr. Fried's observation is of interest and is another factor supporting the prenatal onset of abnormalities in most of these infants. An explanation of its occurrence could be hypoplasia of the intercostal muscles, comparable to the diaphragmatic hypoplasia observed in some of our patients, and to the reduced fetal swallowing probably responsible for the high incidence of hydramnios. It would seem more likely that the thin ribs are a secondary aspect of this widespread intrauterine muscle hypoplasia, rather than a primary abnormality of bone.

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