and the problems were not shown to have clinical importance. The investigators rehydrated the children using an intragastric drip.

We successfully treated a large number of children from 2 months of age upwards with the solution recommended by the WHO. We normally give the solution as a drink, when the children's thirst controls the amount they take in, and we have found no problems with salt overload. Only in the relatively few children given the solution by intragastric drip for specific reasons (most commonly stomatitis, prostration, or excessive vomiting), have we sometimes encountered periorbital oedema among the children a few months old, but this did not appear to influence recovery.

We agree with the generally accepted practice that the oral solution should normally be given as a drink. This is not only pleasanter for the child, but it is the only method suitable for mass use in developing countries, where shortages of trained staff and equipment will generally be much greater than in the conditions of the study in the Calcutta Medical College Hospitals. This method also allows for the close collaboration of the mother in her child's treatment with its potential for health education; and evidently it may be safer.

The common problem in poor conditions with inexperienced mothers and lack of staff is not overhydration but that the child will be given insufficient fluid. In these conditions the solution of higher sodium content is more practical since the volumes needed are less. Additional free water is neither necessary nor recommended. In Mozambique the national policy (Melamed and Segall, 1978) is to use the solution recommended by the WHO.

References

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Dr Chatterjee and co-workers comment:

We thank Dr Vinhas *et al.* for some very pertinent comments on our paper on oral rehydration in infantile diarrhoea. They treated a group of children with diarrhoea with the oral solution recommended by the WHO and did not have any significant problems of salt overload. Furthermore, they administered the fluid as a drink, except in a few cases where a nasogastric tube was used. We preferred the use of a nasogastric tube for the following reasons: (1) we studied only those children with moderate and severe dehydration; they were very sick and were not well enough to drink, and rapid rehydration was mandatory; (2) as this was a controlled clinical trial, use of a nasogastric tube was preferred to reduce the variability in fluid administration, and (3) aspiration of

stomach before administration of fluid, particularly in infants who received loads of antidiarrhoeal medicines before admission, reduces the chance of vomiting. Vomiting is also less likely if the child sleeps while receiving the fluid through a nasogastric tube and is not disturbed to take the drink. We agree that for mass use, if rehydration can be started early, fluid given as a drink is the method of choice and the use of a nasogastric tube should be limited to severely dehydrated infants in cases where quick rehydration is necessary.

The question of salt overload needs a detailed analysis. Although Dr Vinhas *et al.* did not mention the severity of the dehydration, we assume that most of the children had milder dehydration as they were well enough to drink. Even so, while attempting adequate hydration in a few of the severe cases through a nasogastric tube with the solution recommended by the WHO, periorbital oedema occurred in some of them. According to Dr Vinhas, in children receiving the oral fluids by mouth, amelioration of thirst limits the intake. In our experience, however, this is not always so and on many occasions the children continued to drink excessive amounts and developed periorbital oedema. It is pertinent to mention that the estimated episodes of diarrhoea in Asia, Africa, and Latin America in 1975 is 348.2 millions in children aged under 2 years (Rohde and Northrup, 1976). Therefore, if hypernatraemia occurs even in one in a thousand, it will lead to a problem of salt overload in an enormous number of children. We strongly feel that a recommended oral fluid for mass use in the field where supervision is inadequate, should have a higher margin of safety and that the low sodium solution being equally effective should serve this purpose.

Reference

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Prophylactic diazepam in febrile convulsions

Sir,

We read with interest the paper by Knudsen and Vestermark (*Archives*, 1978, 53, 660) shedding some new light on an old controversy about preventing febrile convulsions (FC). The authors stated that: (1) continuous treatment with phenobarbitone had no advantage over intermittent diazepam; (2) the administration of diazepam was not optimal, so that 80% of children received it too late; (3) diazepam is safe, quickly absorbed, free from undesirable side effects, and, unlike phenobarbitone, is subject to little parental resistance; (4) diazepam may be an alternative prophylaxis of FC, but further controlled investigations are needed.

We performed such an investigation in 1973-75 and checked the results in 1977 (follow-up 18-52 months).