of values for normal children of this age is 0.7–1.1 which compares with the values given by Phillips and Vassilopoulou-Sellin.² Our observations of somatomedin activity in this condition, although conflicting with those of Robinow and Shafer, are supported by those of Ashton and Aynsley-Green.³

The difference between our findings and those of Professor Robinow could be due to the difference in the assays used. Both my results and those of Ashton were obtained with bioassays to determine somatomedin activity, while Robinow and Shafer used a radioimmunoassay. Direct comparison of somatomedin activity between the two types of assay used is difficult to make, particularly as the normal range quoted by Robinow and Shafer (0.4–2.0 U/ml) would cover the complete range of somatomedin activity (from hypopituitarism to acromegaly) in most bioassay systems.

No results are presented by Robinow and Shafer for insulin levels; however, the hypoglycaemia in their patients must presumably have been due to hyperinsulinaemia. These results are therefore interesting as, to my knowledge, no other such association between high insulin and low somatomedin has yet been demonstrated. Similarly, it is also difficult to reconcile the gigantism of the Beckwith-Wiedemann syndrome with low somatomedin levels, and I know of no other reported cases of such excessive growth in the absence of somatomedins.

If the difference in somatomedin levels is due to the different assays used, then either there is a factor which interferes in the radioimmunoassay, or the somatomedin-C radioimmunoassay used fails to cross-react with any of the other recognised somatomedins, or there is, in patients with Beckwith-Wiedemann syndrome, a previously unrecognised serum growth factor which is capable of stimulating growth *in vivo* and cartilage growth *in vitro*. This may be a modified (non-immuno-reactive but biologically active) somatomedin molecule.

The conflict in these results should be investigated.

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Accidental poisoning preceding nonaccidental injury

Sir,

Factors that might indicate children to be at risk from nonaccidental injury have been studied extensively.¹

Birth factors such as young maternal age and admission to a special care unit have been shown to be important, but factors after birth have been difficult to assess. We have studied the medical records of 80 children on the South Glamorgan Area Review Committee Child Abuse Register, particularly in respect of admissions to hospital for poisoning before the episode of abuse. All of the children had been either physically injured or had suffered clearcut neglect before age 5. The records of 80 control children, whose names were obtained from the Cardiff Birth Survey and matched for age and sex, were also studied.

Ten of the 80 abused children had poisoning episodes before their placement on the register for child abuse. Three of them had taken salicylates, three benzodiazepines, two domestic bleach, one sherry, and the other unknown tablets. Two of the control children had been admitted for poisoning episodes, one after ingesting perfume and the other after paediatric metoclopramide (Maxolon). The difference between the cases (10) and controls (2) is significant, $P < 0.05$ χ^2 4.41.

Although nonaccidental poisoning is recognised as a type of child abuse,² we believe that the episodes we describe were accidental, indicating family stress which has been shown to be a factor in child poisoning³ and other accidents.⁴ These figures are a further indication that child poisoning should be considered as an important symptom of family problems and should alert all those concerned in the primary care of children.

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Should handicapped children attend ordinary schools?

Sir,

I read with interest the annotation by Rosenbloom,¹ but time has changed the significance of much of what was

written. In August 1980 a White Paper entitled 'Special needs in education' was presented to Parliament by the Secretary for Education and Science, and this stated that the Government does not propose to bring into force section 10 of the Education Act 1976 because it would entail perpetuating the concept of categories of disability, and would give no opportunity for the expression of parental preference. Circular HN (80) 23, which deals with the intended new legislation, should be studied by all paediatricians.

Reference

- ¹ Rosenbloom L. Should handicapped children attend ordinary schools? *Arch Dis Child* 1980; **55**: 581-2.

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Dr Rosenbloom comments:

I thank Dr Graham for her clarification of the current Government proposals in respect of the integration of handicapped children into ordinary schools; the White Paper to which she refers was unpublished when my

annotation went to press. However, it should be pointed out that although it is not now intended to implement section 10 of the Education Act 1976 (for the reasons stated by Dr Graham) the Government agrees with the principle of integration and modified legislation to this effect is proposed. I think there may be more important priorities in special education, and I believe that this is given extra credence by the acknowledgement in the White Paper that, even at best, no extra resources have been made available for the implementation of the recommendations set out in the Warnock Report.¹

Paediatricians may not know that in Circular HN (80) 23 they, and other Health Service personnel, are invited to comment on the proposals contained in the White Paper; it is important that anyone who has handicapped children as patients should study these.

Reference

- ¹ Warnock M, chairman. *Special educational needs. Report of the Committee of Enquiry into the Education of Handicapped Children and Young People*. London: HMSO, 1978.

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