excluded, only 2 of the remaining 132 unselected children had serious renal disease at long-term follow-up (for one of whom the disease was fatal). Thus the prognosis of an unselected series of children with HS syndrome and nephritis seems to be better than more selective series have reported.²

We thank the Sigrid Jusélius Foundation for generous support.

Correspondence

Perinatal mortality

Sir,

Pamela Davies in Current topics¹ reviewed the recommendations of the Short report² and commented unfavourably on them, if I understood her correctly, for three reasons.

Firstly, she said that money would be better spent on primary care and prevention of prematurity. In theory there is some truth in this view, but what evidence does she have that such expenditure would affect either the prematurity or the perinatal mortality rate. Can she quote any controlled studies to prove it? After all, as Dr Davies stated, the great improvement in the standard of living in the UK since the war has not been associated with any change in the prematurity rate. Before we spend more money indiscriminately on primary care in the fond hope that there will be some 'spin-off', let us have some clear evidence that money so spent is likely to have the desired effect.

Secondly, she implied that as money is in short supply because of the policies of the present government, we should not complain bitterly about lack of perinatal provision. What an amazing counsel of inertia from a senior paediatrician, and what an abrogation of professional responsibility. Surely one should ensure that hospital facilities for seriously ill neonates are constantly upgraded and improved.

Thirdly, she questioned whether expenditure on neonatal intensive care would have any major effect in preventing handicap. In many of these arguments I must agree with her, since I believe that the proportion of the total handicap generated in low birthweight infants is very small. However, the data showing there has been no major change in the numbers of handicapped infants arising from neonatal intensive care units, despite modern intensive care, can be interpreted in two ways. Dr Davies seemed to imply that since more intensive care has not reduced the absolute amount of handicap, it was not worth spending money on neonatal intensive care. This really is a fatuous argument. I would subscribe to the view that the fact that modern neonatal intensive care saves

References

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the lives of increasingly large numbers of babies *without* increasing the absolute numbers of handicap is a major vindication of the techniques of neonatal intensive care.

Let there be no doubt that neonatal intensive care does save lives. Comparison of the national figure for mortality in infants of 1.0-2.0 kg birthweight with that reported from committed neonatal intensive care units leads very quickly to the conclusion that about 2000 low birthweight infants die of neglect in premature baby units each year in England and Wales.

What was particularly staggering about Dr Davies's comments that we should not be getting more for neonatal intensive care was that she seemed to be unaware of what was happening on her own doorstep. Does she not know that paediatricians in the North West Thames Area are unable to find places for critically ill infants of low birthweights in the regional neonatal intensive care units in London, including her own at Hammersmith, because they are bursting at the seams? I certainly know it because often I have to take their babies into our own under-funded and under-equipped East Anglian intensive care unit at Cambridge; therefore I find it particularly galling to have my attempts to raise funds and improve facilities for the Cambridge unit described as 'money grabbing' and 'empire building'.

References

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Dr Davies comments:

Dr Robertson asks if I can quote any controlled study to prove that expenditure on primary care would (favourably) affect the prematurity (low birthweight) or perinatal