reject 12% of their samples, even in well motivated children. This further emphasises to us the difficulty, which we have found in our own studies, in the collection of accurately timed and measured volumes of urine in children. The use of urine albumin:creatinine ratio obviates the need for timed or measured samples and correlates well with albumin excretion rates,² and we would suggest this as an ideal method for further study of albuminuria in children. In our own studies of diabetic children, a group that require repeated assessment of renal function, it has become evident that some form of stress is necessary to unmask latent glomerular damage. Using urine albumin:creatinine ratio urine specimens taken before and after exercise we have identified 20 out of 60 diabetic children (compared with none in a control non-diabetic group) with abnormal albumin excretion, but who have normal values for albumin excretion rates and urine albumin:creatinine ratios on random and timed 24 hour split urine collections.

We would also echo the plea for standardisation of units. The authors chose to use SI units of mg/mmol for their urine albumin:creatinine ratio rather than the original mg/mg, which has the merit of not mixing units and is comparable with most previous data without a difficult conversion (1 mmol=113.1 mg creatinine). We would suggest continuing with mg/mg for the measurement of urine albumin:creatinine ratio.

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Congenital diaphragmatic hernia: association between pulmonary vascular resistance and plasma thromboxane concentrations

Sir,

The report by Ford *et al*¹ of an association between plasma prostanooids and pulmonary vascular tone was extremely interesting. In the initial paragraph of the 'Results' section, however, they note an alveolar-arterial difference in oxygen tension (A-a Do₂) of 550 mm Hg. The alveolar air equation has undergone numerous revisions since first suggested by Benzinger,² but in its simplest form alveolar Po₂ is derived by first subtracting water vapour pressure from atmospheric pressure and then further subtracting the result of the arterial PCO₂ divided by the respiratory exchange ratio. Assuming a Paco₂ of 30 mm Hg, the A-a Do₂ would then become 446 mm Hg. Furthermore, infusion of tolazoline did not seem to eliminate the right to

left shunt, or venous admixture, but the infusion did succeed in reducing the shunt to somewhat less than that noted five hours after surgery, which might be roughly estimated as about 20%. Had tolazoline completely eliminated the shunt and produced a Paco₂ near 675 mm Hg, a rather new and more startling explanation would seem to have been required. These points are offered in clarification; the work is noteworthy and potentially quite important.

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Dr Ford and co-workers comment:

We calculated our alveolar-arterial difference in oxygen tension (A-a Do₂) using the umbilical artery as the source of arterial oxygen rather than the radial artery. Thus we derived an A-a Do₂ of approximately 550 mm Hg. This has been used previously to attempt to determine prognosis in these neonates.³

Obviously we have failed to clarify the degree of shunt at the various points in time. At the time of surgery, as the radial artery Pao₂ was less than the expected level on an F₁O₂ of 1.0, we assumed there was a shunt at the cardiac level plus or minus a ventilation-perfusion mismatch. At the same time point, the difference between the radial and umbilical artery was assumed to represent ductal shunting. When the radial and umbilical oxygenation levels became the same at 15 hours after surgery and then both dropped, we assumed that shunting was occurring at the foramen ovale or there was a gross ventilation-perfusion mismatch, or both. Tolazoline improved this situation dramatically and at the same time thromboxane concentrations fell. We at no stage attempted to quantify the shunt.

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Medical contribution to the management of dyslexia

Sir,

What Drs Gordon *et al* allude to in their paper,¹ but perhaps should have clarified, is the way in which parents involve doctors—which is often as follows. Their child is not doing well at school. The head teacher has a talk with them and may mention referral to the educational psycho-

logist. The parents cannot accept that their child is backward, and they have an instinctive mistrust of psychologists. They have heard of dyslexia and latch on to the idea that their child might have it. Dyslexia is a popular and acceptable thing to have whereas being backward is not. They consult the family doctor, who refers the child to the local paediatrician. Constraints of time make the general paediatric clinic unsuitable for the assessment of these children. The general practitioner may also refer the child to the senior clinical medical officer in the School Health Department. He or she will have wide experience of the range of special educational needs.

The consultant paediatrician can perform a neurological examination to rule out obvious organic neurological pathology. A developmental assessment may be performed, but this is time consuming. It will, however, certainly be carried out if the senior clinical medical officer is present, as should be the case in an assessment unit or in joint assessment clinics. Listening to the parent and taking a meticulous history of the child and family are also time consuming but vitally important. At the conclusion the parents can be counselled that the person most qualified to decide whether the child actually has dyslexia, dyscalculia, etc is in fact the educational psychologist, who is also in a position to determine educational needs. He or she may institute a multidisciplinary assessment (Education Act 1981) to which the above mentioned doctors will be able to contribute.

Another problem is that local branches of the Dyslexia Institute (who employ their own educational psychologists) give the impression in their leaflets firstly, that dyslexia is common and that any one of a large number of learning problems may point to it, whereas some educational psychologists in the local education authority service feel it is very rare. Secondly, there are implications that its management requires completely different teaching techniques (available at the institute) from those of school 'remedial teaching' and that the latter may do harm in these children. The psychologists need to reach an agreement on this issue.

Reference

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Inquiries into perinatal and early childhood deaths in a health care district

Sir,

Professor Brimblecombe and colleagues describe a method of monitoring peri- and post perinatal deaths.¹ The reader

might gain the impression that this is a new aspect of research. Many areas have monitored post perinatal deaths and confidential enquiries were recommended as early as 1970. Confidential enquiries into post perinatal deaths have been carried out in Sheffield since 1973, and in 1979 became part of routine health services.^{2,3} The importance of the Exeter study lies in combining peri- and post perinatal deaths. We found that 13 of a total of 101 post perinatal deaths were the result of 'perinatal causes', and this proportion seems to be increasing. Brimblecombe dealt with only 62 deaths: larger health districts with over 100 deaths annually have more problems. When we attempted to extend into the perinatal period we found that the necessary staff were not available. Brimblecombe is aware of the financial problems and has made this the subject of recommendations elsewhere. Could he expand on this?

In our enquiries an evening home visit is now always made by a doctor rather than a nurse, but our greatest advance has been to hold the case conference on non-hospital deaths in the family doctor's surgery, and we strongly recommend this. Surgery based conferences are usually attended by at most six people with direct involvement and produce information that would not be presented at hospital conferences. Hospital doctors also gain understanding of community problems.

Regarding audit; confidential information should result in improvements in services. We find that the best method is to hold regular meetings with senior medical and nursing administrators to discuss the results of all case conferences. Changes in services are initiated and confidentiality is maintained without a public report.⁴ We believe that it is only through confidential enquiries that understanding of at least some cot deaths will be attained.

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Professor Brimblecombe comments:

I am sorry if any reader gained the impression from our paper that I regarded confidential inquiries into perinatal and early childhood deaths as a new subject for research. There are so many well known published reports on this topic that I had not thought it necessary to append a full