should be a dialogue twixt paediatrician and pharmacist, not houseman and computer.

Reference

- ¹ MacMahon P. Prescribing and formulating neonatal intravenous feeding solutions by microcomputer. *Arch Dis Child* 1984;59:548-52.

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Dr MacMahon comments:

Dr Davies and Mr Leivers comment that they have not found it necessary to make frequent adjustments to their parenteral nutrition regimens and that they therefore usually use one of three standard formulas. I have in the past worked in a major referral unit which used a similar system. I agree that apparently satisfactory parenteral nutrition is indeed possible with such a system when the infant is metabolically stable. There is an inevitable tendency, however, with such a system to either postpone the initiation of parenteral nutrition in the metabolically unstable infant or to tolerate minor electrolyte disturbances rather than alter a standard solution.

In my experience allocating the problem to a senior staff member does not protect against mistakes. In the increasingly complex environment of a modern neonatal intensive care unit errors of all sorts are all too common. I believe that computers should be used whenever possible to help alleviate this problem.

The clinical importance of minor electrolyte disturbances is certainly debatable. In the context of the availability of inexpensive microcomputers I do, however, submit that it is manifestly absurd that arithmetical complexity alone should act as a constraint on optimal clinical management.

Glass furniture hazard

Sir,

We were interested to read Bell's recent report¹ on glass injuries. About 50 children are admitted each year to the children's ward at Moorfields Eye Hospital with serious eye trauma and these constitute about five per cent of all admissions to the department. The injuries are caused by a variety of agents, ranging from darts, arrows, balls, bushes, broken glass, and fireworks to airgun pellets, dog bites, drawing pins, scissors, and bomb incidents. The number of serious eye injuries due to broken glass has remained relatively constant in the last few years (see Table), although there have been interesting changes in the traumatising agents.

Just as legislation in the sale of fireworks to minors has led to fewer firework injuries to the eyes, we are now witnessing fewer ophthalmic tragedies due to shattered windcreens, presumably attributable to accident prevention propaganda and the recently introduced seat belt legislation. Unfortunately, the new vogue in glass

Table Number of injuries due to broken glass in relation to total admissions due to trauma

Year	Total admissions	Admissions due to trauma	No of serious injuries due to broken glass
1980	1150	59 (15 girls, 44 boys)	5
1981	1280	53 (13 girls, 40 boys)	6
1982	1102	48 (7 girls, 41 boys)	5
1983	1035	55 (11 girls, 44 boys)	7

furniture, particularly large coffee tables and glass doors is becoming a major hazard in the home. In the past year we have seen a child who lost an eye and another who required corneal grafting after simple accidents which led to the shattering of glass table tops.

Unlike Dr Bell we feel that educating supervising adults about the dangers of glass in the home gives only partial grounds for optimism in reducing accident rates, as most parents perceive accidents to be outside their control.² Improved product design using safety glass in furniture would minimise environmental hazard and probably reduce accident rates. Legislation has had considerable success in accident prevention in other areas³ and we believe this to be the most fruitful strategy in reducing serious childhood accidents due to broken glass.

References

- ¹ Bell D. Two hundred glass injuries. *Arch Dis Child* 1984;59:672-3.
² Langley J, Silva P. Childhood accidents—parents' attitudes prevention. *Aust Paediatr J* 1982;18:247-9.
³ Beautrais AL, Fergusson DM, Shannon FT. Childhood accidents in a New Zealand birth cohort. *Aust Paediatr J* 1982;18:238-42.

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Treatment choice in acute rheumatic carditis

Sir,

We read with interest the paper by Human *et al*¹ regarding steroid treatment in acute rheumatic fever. We also think that steroids should be used in each case of rheumatic fever with carditis, regardless of the severity of the carditis. Two unresolved questions were raised by the authors: the dosage and duration of steroid treatment. Continuous steroid treatment for three weeks, as practiced by Human, may cause suppression of the hypothalamic-pituitary-adrenal axis, with all its consequences.² Furthermore, as the natural history of rheumatic fever is six to eight weeks, it is recommended that treatment be given for this period.³ To overcome these two problems we have been treating patients suffering from rheumatic fever with carditis with alternate day steroid treatment.

For the past 10 years we have treated more than 50 patients with 2 mg/kg day of prednisone in the first week and alternate day treatment with decreasing dosage for another five weeks. All responded with decrease of erythrocyte sedimentation rate and improved clinical condition. None of the patients had side effects related to steroid treatment, and no weight gain or Cushingoid facies were noted.

We recommend, therefore, that all patients with active rheumatic fever with carditis receive alternate day steroid treatment for a period of six weeks.

References

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Publication of abstracts

Sir,

I would like to endorse strongly Professor Strang's observations concerning the need for abstracts to be published.¹ The abstract is a most important source of information to any investigator actively pursuing the latest information in his field. If he is unable to attend the relevant meeting to hear a presentation, he would have to wait until the work was fully published—usually a substantial period of time, often months, sometimes years. If he lives in centres geographically remote from Europe and North America, for example Australia and New Zealand, and is thus infrequently or never able to attend scientific meetings in the northern hemisphere, he will be considerably disadvantaged in relation to current research in his field of interest, having to rely on published work alone. It seems to me to be an unacceptable elitism for those working in countries with relatively small distances for travel and ease of access to scientific information, to restrict exchange of information by failing to publish abstracts as the editor of *Archives* recommends.

There is no doubt that at present many abstracts are shoddy and inadequate. Surely what must be done is not to censor abstracts by failing to publish them, but to edit them appropriately to ensure a free exchange of ideas around the world. Finally, to forbid reference to abstracts is quite unreasonable. This means primacy of observation may be overridden by a secondary group who, having heard work presented may quickly repeat it and upstage the original by rapid publication. I would urge that high standard abstracts continue to be published.

Reference

- Strang LB. Abstracts—are they really a dud currency? (letter). *Arch Dis Child* 1984;**59**:902.

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Cleft palate and gonadotrophin deficiency

Sir,

We read with interest the paper by Tuohy and Franklin.¹ Their patient had 'some degree of hyposmia' in addition to a cleft lip and palate, bilateral cryptorchidism, and isolated gonadotrophin deficiency.

We submit that these features correspond to the Kallmann syndrome, described in 1944.^{2,3} In this disorder, a developmental defect of the olfactory lobes is combined with an isolated gonadotrophin deficiency. Other defects include cryptorchidism, midline craniofacial abnormalities (cleft lip, cleft palate, or both) and deafness. The condition is classified by McKusick⁴ as either autosomal recessive, dominant or X-linked, with variable expression.

References

- Tuohy PG, Franklin RC. Cleft palate and gonadotrophin deficiency. *Arch Dis Child* 1984;**59**:580-2.
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Drs Tuohy and Franklin comment:

The subject's hyposmia was at worst mild when formally tested, whereas most males with the so called Kallmann syndrome have severe olfactory impairment. He was not eunuchoid, deaf, colour blind, or mentally retarded; nor did he have syndactyly. The case was sporadic and no first degree relative had any of the 'associated' abnormalities. The possibility that the degree of hyposmia could be a complication of the subject's nasal pathology, together with the lack of supporting evidence, detract from the diagnosis of Kallmann's syndrome.