Aberdeen when I was there a few years ago. Handling for radiography is probably less risky than direct inspection.

By excluding from radiological examination the five cases of acute epiglottitis the Glasgow workers have excluded the five cases in which neck radiographs would have been diagnostic, so it is not surprising that Goel concludes that neck radiographs were unhelpful.

References

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- ² Illingworth RS. *Common symptoms of disease in children*. 7th Ed. Oxford: Blackwell Scientific Publications, 1982:152.
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Dr Goel comments:

I was interested to read Dr Porter's comments on my letter.¹ I think most would agree that the diagnosis of acute epiglottitis should be made on the history, general appearance of the child, and the quality of stridor. A lateral radiograph of the neck as suggested by Dr Porter is a useful diagnostic investigation provided expert radiological interpretation is available. This is not always the case, especially at night. Furthermore we would not recommend this procedure in infants in whom acute epiglottitis is suspected simply because the handling necessary to obtain adequate films may be very disturbing to the child and may also precipitate acute obstruction. In view of this, if there is doubt about the diagnosis direct inspection is the only appropriate method. I agree entirely with Dr Porter that under no circumstances should this be carried out unless there are adequate facilities available to relieve acute obstruction immediately should it occur.

In this hospital routine radiographs of the neck and chest are now carried out only to exclude the possibility of a foreign body inhalation and are not included in the work up of croup syndrome.

Parental reaction to auditory response cradle testing

Sir,

I was interested to read the paper by Drs Bhattacharya, Bennett, and Tucker on the follow up of newborn babies tested with the auditory response cradle.¹ The devastating consequences of delayed diagnosis of hearing loss to language and speech development are only too well known. I should like to ask how parents accepted the news that their babies might be unable to hear? Were many

frustrations expressed by the parents with regard to possible over optimistic expectations raised as a result of such an early diagnosis of hearing loss without immediately available treatment? So many of the problems of screening do not relate to the test itself but to coping with the many consequences, medical, psychological, and social, of making a diagnosis.

Reference

- ¹ Bhattacharya J, Bennett MJ, Tucker SM. Long term follow up of newborns tested with the auditory response cradle. *Arch Dis Child* 1984;**59**:504-11.

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Dr Tucker and co-workers comment:

We thank Professor Davies for drawing attention to the aspect of parental reaction to auditory response cradle testing. In our paper, we did not discuss this in any detail, but it is an essential part of our general approach with the parents. At the onset of the testing the parents are informed that this is a screening technique only and not a diagnostic one, and should the baby fail the cradle on two occasions further diagnostic tests will be done almost immediately to confirm whether there is indeed hearing loss. As we are able to confirm the diagnosis within a day or two of the cradle test, we have been able to observe the parents' reactions to this early diagnosis and there were few adverse comments by any of the parents concerned. The ability to make an early diagnosis of hearing loss without being able to provide treatment is self defeating, so we have researched this aspect in some detail, and try to provide amplification as early as possible. We would agree with Professor Davies completely in his philosophy inherent in making an early diagnosis, and we therefore spend considerable time discussing the medical, psychological, and social implications of such a diagnosis with the parents. The advantage of reliable early diagnosis together with the ability to offer immediate treatment outweighs all the other disadvantages, but we remain deeply concerned and involved in helping parents accept the diagnosis.

Selective bronchial intubation for pulmonary emphysema

Sir,

During the past 10 months we have encountered in our neonatal unit five preterm infants (mean birthweight 1.24 kg, range 0.94 to 1.64 kg; mean gestation 29 weeks, range 27 to 30 weeks) with unilateral pulmonary interstitial emphysema. Our experience with selective bronchial intubation as a treatment for this condition is not as encouraging as that reported by Drs Campbell, Zarfin, and Perlman.¹

Three of the five infants were treated with selective intubation. One infant was suffering from a right sided and two from left sided lesions. A total of four selective intubations were carried out for a mean duration of 60