Professor Milner comments:

May I reply to Dr Wright's points in turn:

(1) We entirely agree and in fact stated in the text that the introduction of apnoea monitors was based on the hypothesis that 'babies dying from sudden infant death have cessation of breathing probably for longer than 30 seconds before death or irreversible brain damage has occurred'.

(2) There are published reports of babies dying while attached to monitors.^{5 6}

(3) We would agree that the Graseby MR 10 is the most commonly used monitor but it is certainly not the only device used in the United Kingdom.

(4) Since we do not know how babies are victims of sudden infant death syndrome we do not know whether obstructive apnoea is an important factor, but studies have shown that obstructive apnoea certainly occurs in babies suffering near miss sudden infant death, who are often provided with apnoea monitors for use at home.⁷

(5) We would certainly agree that false positive alarms can sometimes reassure parents that the device is working, although in our experience frequent alarms often cause the parents to stop using monitors after relatively short periods.

References

- 1 Foundation for the Study of Infant Death and the British Paediatric Respiratory Group. Apnoea monitors and sudden infant death. *Arch Dis Child* 1985;**60**:76-80.
- 2 Orlowski JP. The effectiveness of pediatric cardiopulmonary resuscitation. *Am J Dis Child* 1984;**138**:1097.
- 3 Callan K, Wright BM. *Proceedings of the 3rd International conference on ambulatory monitoring*. London: Academic Press, 1980:329-34.
- 4 Stewart-Brown S. Personal view. *Br Med J* 1982;**284**:1628.
- 5 Kelly DH, Shannon DC, O'Connor K. Care of infants with near-miss sudden infant death syndrome. *Pediatrics* 1978;**61**:511-4.
- 6 Lewak N. Sudden infant death syndrome in a hospitalized infant on an apnoea monitor. *Pediatrics* 1975;**56**:296-8.
- 7 Guillemainault C, Ariagno R, Korobkin R, *et al*. Mixed and obstructive sleep apnea and near miss for sudden infant death syndrome. 2. Comparison of near miss and normal control infants by age. *Pediatrics* 1979;**64**:882-91.

Costs and outcomes in a regional neonatal intensive care unit

Sir,

News *et al*¹ report the costs of intensive neonatal care in Birmingham in 1980 and 1981. In succeeding to calculate the costs of this service to the National Health Service they are to be congratulated. No similar data are available. There is, however, the danger that in the absence of other cost evaluations many health authorities may use this information as a benchmark to price their own services now that 'Sainsbury' style management is imminent.

Nursing staff salaries, the major component of their costs, have risen considerably in excess of the average compounded inflation rates. Furthermore, the nursing

staff levels at Birmingham Maternity Hospital not commented upon directly by the authors were, in 1981 to 1983, to quote a West Midlands Health Authority report 'grossly unsatisfactory in the ratio of trained to untrained staff and unsatisfactory at night'.

That they cared so well for their neonates while being so short staffed is to their credit but for those of us being called upon to project the present costs for intensive neonatal services a more realistic estimate would be to double the quoted figures.

Reference

- 1 News B, Drummond MF, Durbin GM, Culley P. Costs and outcomes in a regional neonatal intensive care unit. *Arch Dis Child* 1984;**59**:1064-7.

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Clinical significance of gastro-oesophageal reflux

Sir,

Am I to assume that Professor Carré examines radiologically all regurgitating babies he sees?¹

Reference

- 1 Carré IJ. Clinical significance of gastro-oesophageal reflux. *Arch Dis Child* 1984;**59**:911-2.

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Professor Carré comments:

Dr Connor is mistaken in his assumption. There was indeed a time when I would have had the great majority of regurgitating infants examined radiologically, but resulting from experience gained at that time only selected cases have been studied in this manner during the past 10 to 15 years. These comprise infants with persistent and particularly troublesome regurgitation, especially if associated with occasional vomiting or other clinical disturbance such as respiratory illness, and all younger regurgitating siblings of children with a partial thoracic stomach.

Coagulation defect in congenital tyrosinaemia

Sir,

We agree with Professor Özsoylu¹ that low fibrinogen