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In Ontario home monitoring was stopped at an average age of just under 8 months.²

Judging by the dozens of letters I have received over the years, most parents found home monitoring very effective in relieving their anxiety, despite having been warned that babies have died while on such equipment. Further evidence for this is that well over 90% of parents who have had one infant on home monitoring equipment request monitoring for their subsequent children.

References

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The school entry medical examination

Sir,

Whitmore and Bax put forward a cogent argument for retaining and improving the school entry medical examination.¹ They point out that a fairly high proportion of children do not receive satisfactory health surveillance during their preschool years and emphasise the importance of the child receiving health care in relation to his functioning in school.

It is disappointing that such a comprehensive assessment does not attempt to identify children with asthma, a condition that causes a great deal of avoidable disability in schoolchildren. Recent community based studies have shown that roughly one in nine primary schoolchildren will have had recurrent episodes of wheezing by the age of 8 and that many of these children will not have been diagnosed as having asthma.² Failure to make the diagnosis of asthma is often associated with frequent absences from school, poor educational performance,³ and inappropriate or inadequate treatment. This state of affairs is particularly unfortunate with a condition that is so easily diagnosed and where effective treatment is so readily available.

There is no evidence that the management of childhood asthma is improving. Indeed, admissions to hospital continue to increase and the number of deaths from asthma in children and young adults has almost doubled over the past decade.⁴ It is apparent that unless the diagnosis is made treatment will not be given. School doctors and school nurses are in a unique position and could easily identify most children with asthma by including the simple question 'Has your child ever wheezed?'² in their interviews or questionnaires. While this would not solve the problems of underdiagnosis and undertreatment, it would at least be a useful first step.

References

- Whitmore K, Bax M. The school entry medical examination. *Arch Dis Child* 1986;**61**:807-17.

² Speight ANP, Lee DA, Hey EN. Underdiagnosis and undertreatment of asthma in childhood. *Br Med J* 1983;**286**:1253-6.

³ Anderson HR, Bailey PA, Cooper JS, Palmer JC, West S. Morbidity and school absence caused by asthma and wheezing illness. *Arch Dis Child* 1983;**58**:777-84.

⁴ Khot A, Burn R. Deaths from asthma. *Br Med J* 1984;**289**:557.

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Drs Bax and Whitmore comment:

We are grateful for Dr Couriel's comments. We did not include in our account the details of our parent questionnaire/interview, in which we do of course make enquiries about the child's history of respiratory illness. Apart from examining the child we have been reviewing, since the publication of the papers Dr Couriel refers to, the management of asthma in all children we see in school. We did emphasise in the paper that discussion on the management of illnesses, including asthma, is very much a part of the school doctors' and nurses' task.

Improvements in child resistant containers

Sir,

In 1985 you published our paper that suggested that the voluntary agreement between the government and the pharmaceutical profession on child resistant containers had not resulted in a significant fall in accidental child poisoning in South Glamorgan.¹ Since that time we have been approached about whether we had evidence whether blister (or unit) packs were as effective as child resistant containers in preventing accidental child poisoning. It has occurred to us that it is possible to use data within our paper to answer this.

We have compared the type of packaging used in the cases of accidental child poisoning in children under 5 years with solid dose prescribable medications (excluding aspirin and paracetamol) admitted to hospital in South Glamorgan for the years 1983, 1984, and 1985 with the type of packaging of similar medications in general use in South Glamorgan estimated by those handed into our pharmacy by patients admitted to our hospital in 1985. We have added 1985 figures for poisoning admissions to those contained originally in our paper (Table).

Table Comparison of types of packaging used in cases admitted to hospital because of poisoning in 1983-85 and in the general population in 1985

Type of packaging	Group in whom packaging used	
	Cases admitted to hospital due to poisoning	General population
Child resistant container	11	256
Blister or unit packs	26	78
Ordinary container	77	469
Unknown	8	0