consider that the data support the presence of the disease in older children as well. Clearly, Bitot's spots do not always indicate the presence of active xerophthalmia in children over 6, a point made in the original paper. The extent of severe malnutrition in all age groups prompted me to examine children up to 14 in this population. It was an unprecedented situation, which I thought merited a wider sample size than normally used.

While Dr McLaren thinks that corneal xerosis cannot be diagnosed without a slit lamp, numerous other investigators have reported corneal xerosis in prevalence surveys performed without a slit lamp. In fact, the WHO 'Field guide to the detection and control of xerophthalmia' states that '(corneal xerosis) is easily diagnosed and highly specific' and makes no mention of the use of a slit lamp to make this diagnosis.¹ I feel confident in the diagnosis as stated in the paper.

Finally, and most disturbing, is the point made by Dr McLaren that while the WHO guidelines are not engraved on stone tablets, they should stand until new data become available. The point of this paper is to suggest that in severe disaster situations just such a revision may be indicated. It is time for this issue to be discussed in an open forum to prepare for the next disaster, which most unwelcomely and assuredly will arise.

Reference

- ¹ Sommer A. *Field guide to the detection and control of xerophthalmia*. Geneva: WHO, 1978.

Meningitis presenting as hypertension

Sir,

I have just read the report by Waters and Gillis of meningitis presenting as hypertension.¹ A month ago I was called urgently to see a child with haemophilus meningitis who had developed severe hypertension. The hypertension was cured instantly by using an appropriately sized sphygmomanometer cuff. Reports involving blood pressure measurement in children should always give precise details of how the blood pressure was measured.

Reference

- ¹ Waters K, Gillis J. Meningitis presenting as hypertension. *Arch Dis Child* 1987;**62**:191-3.

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Meningitis due to *Haemophilus influenzae* type b resistant to ampicillin and chloramphenicol

Sir,

The recent report by Fraise *et al* of multiply resistant *Haemophilus influenzae*¹ makes reference to two previous

reports of resistance found in this organism from the United Kingdom² and the United States.³ I suspect the authors did not take the time to read the reference for the USA. If they had it would have been clear that it was describing resistance in Australia, a country not easily confused with the USA. Even correct reading of the title should have made the error apparent.

Chloramphenicol resistance is now widespread, including reports from Thailand,⁴ the USA,⁵ and the Caribbean.⁶

Readers are entitled not only to accuracy of data but also to diligence and care of presentation.

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- ¹ Fraise AP, Meeks ACG, Richards JE. Meningitis due to *Haemophilus influenzae* resistant to ampicillin and chloramphenicol. *Arch Dis Child* 1986;**61**:1134-5.
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- ⁵ Uchiyama N, Greene G, Kitts D, *et al*. Meningitis due to *Haemophilus influenzae* type b resistant to ampicillin and chloramphenicol. *J Pediatr* 1980;**97**:421-4.
- ⁶ Anonymous. Ampicillin and chloramphenicol resistance in *Haemophilus influenzae* disease (Editorial). *MMWR* 1984;**33**:35-7.

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Drs Fraise, Meeks, and Richards comment:

We have read with interest the comments made by Dr Forsyth. We acknowledge that there was an omission in the introductory phrase of our paper, which should have read '... in the United States and in Australia.' We do not believe a small omission such as this, however, changes in any way the validity of our report or the message it contains.

This correspondence is now closed—ed.

Thrombotest values and effect of vitamin K administration for infants

Sir,

The finding of Garrow *et al* that Thrombotest values decline on the second day of life in breast fed babies but not in those who have received vitamin K at birth is important.¹ Fetal haemorrhagic episodes, including intracranial haemorrhage, are more common at 2 to 3 weeks of age than in the early days of the neonatal period.² Thus the Thrombotest for babies at 2 weeks may also be useful to predict and manage vitamin K deficiency.

We performed the Thrombotest (Thrombotest Owren, Eisai Co, Tokyo) for 437 babies at 2 weeks. Of the 437 babies, 263 were breast fed, 37 bottle fed, and 137 mixed

fed. None of the babies had received vitamin K at any time before this study. A significant difference in the Thrombotest values of breast fed compared with bottle and mixed fed babies was obtained (mean (SD) Thrombotest values for breast fed babies=64.1 (20.0)%, for bottle fed=80.0 (22.7)%, and for mixed fed=73.9 (21.2)%; $p<0.01$). Four of the 263 breast fed babies had Thrombotest values lower than 30% and these babies may be at risk from intracranial haemorrhage.

We prescribed 2 mg of vitamin K₂ intramuscularly or orally to 125 babies (90 breast fed, five bottle fed, and 30 mixed fed) who had low Thrombotest values of less than 60% at 2 weeks. The mean (SD) Thrombotest values for babies with each feed before and two weeks after the vitamin K₂ administration were 48.3 (10.0)% and 88.2 (17.4)% for breast fed babies, 52.4 (8.4)% and 86.5 (16.7)% for bottle fed babies, and 50.0 (6.4)% and 93.0 (11.2)% for mixed fed babies, respectively. Thus the administration of vitamin K increased Thrombotest values and may be effective for the treatment of vitamin K deficiency in babies who are breast, bottle, or mixed fed. The possibility of the spontaneous resolution of vitamin K deficiency cannot be absolutely excluded. Recently, O'Conner *et al* showed that oral administration of vitamin K is also effective for the baby with vitamin K deficiency.³ In our studies, 110 of the 125 babies who received vitamin K orally showed a similar increase in the Thrombotest values to those of intramuscular administration.

References

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- ² Lanc PA, Hathaway WE. Vitamin K in infancy. *J Pediatr* 1985;**106**:351-9.
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Neonatal malaria and obstructive jaundice

Sir,

We enjoyed reading Davenport's paper entitled "Neonatal

malaria and obstructive jaundice" in this journal.¹ We question the use of the term "obstructive jaundice". In Davenport's case there was no extrahepatic obstruction with bile plug. We believe, therefore, that the term "cholestatic neonatal jaundice" should be used in such a condition as we have suggested previously.²

References

- ¹ Davenport M. Neonatal malaria and obstructive jaundice. *Arch Dis Child* 1986;**61**:515-7.
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Dr Davenport comments:

Although I can see the objection to the term 'obstructive jaundice'¹ on the basis that a normal cholangiographic biliary tree is perfectly acceptable, I would like to justify the term on two counts.

Firstly, it is a widely used and understood term and seems more elegant than the biochemically equivalent 'conjugated hyperbilirubinaemia'. It implies a certain pattern of liver function tests—that is, conjugated bilirubin concentration, high alkaline phosphatase activity, and near normal hepatic enzyme activities.

Secondly, microscopically, canalicular cholestasis and intracellular biliary stasis point to a functional obstruction to the excretion of bile after intrahepatocellular conjugation, albeit with a patent extrahepatic biliary tree.

Thus it seems that the term can be retained with some justification on pathological grounds.²

References

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- ² Forfar JO, Arneil GC. *Textbook of paediatrics*. 3rd ed. London: Churchill Livingstone, 1984:184-5.

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