*al.*¹ it would appear that this 'blush' is only diagnosed on parasagittal section. This is therefore not at all comparable with our definition, which must be seen on two planes. In addition, these authors give no information on how long the echos were required before they considered the blush to be abnormal. Indeed, the babies died largely within a few days of age, so clearly this would not fit in with our definition. It is, however, interesting to note that the prevalence of PVL in 68 consecutive liveborn infants dying under two months of age in their unit was 26%. This compares very favourably with the 25% incidence of PVL that we recognised prospectively using ultrasound on our 200 very low birthweight babies.

The point of our study was to set up a prospective database of 200 infants who were scanned sequentially and in whom there was clear understanding of what we meant by our ultrasound appearances. Our definitions were, of course, arbitrary as we did not have the benefit at that time of clinical follow up. We have now completed follow up collection on all the surviving infants and the relevance of our definition of prolonged flare will hopefully soon become apparent.

Reference

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Tracheobronchial suction in ventilated neonates

Sir,

We congratulate Dr Prendiville *et al* on their successful attempt to investigate the efficacy of tracheobronchial suction in ventilated neonates.¹ This aspect of the routine care of ventilated babies has important consequences. Knowing when, how often, and how to perform endotracheal tube toilet is difficult, and their study provides some of the answers. Unfortunately, continuous monitoring of airways resistance by flow-volume integration using a double pneumotachograph system seems unlikely to be practical for routine clinical use.

The single breath technique for determining airways resistance relies on passive expiration. Most ventilated babies with the respiratory distress syndrome make use of their abdominal muscles to expire actively (South M, Morley C J. Expiratory muscle activity in premature babies. Presented to Neonatal Society, November 1986). The authors state that spontaneous respiration was stopped by increasing ventilator rate. This is unusual in our experience. We find that at faster ventilator rates most babies continue to breathe spontaneously but synchronously with ventilator inflations.² When breathing synchronously, they can seem to be apnoeic, with linear flow-volume curves. Expiratory muscle activity often continues during synchronous breathing, and this could shorten expiratory time constants and reduce the calculated resistance. Despite these reservations we are sure that the results of this paper are helpful. We would recommend, however, that an independent method for

detecting the presence of spontaneous respiration should be used.³

References

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Infantile colic and feeding

Sir,

Unfortunately the paper by Ståhlberg and Savilahti¹ adds to the confusion that already exists regarding an association between infantile colic and cow's milk.

They failed to define colic and, therefore, the criteria for entry into the study. The mean age of the babies at entry was nearly 3 months by which time a large number of babies with 'colic' will be improving spontaneously. The duration of feeding on each milk preparation was too short to show any important differences, and there was no washout period between each milk, with the likelihood there will be a carry over effect from the preceding preparation.

Analysis of the data in Table 1 in their paper shows that eight of the ten babies received breast milk first with or without the lactase so that the results do not report adequately on the relative impact of formula followed by breast milk. In addition, if the data are analysed by order of administration of treatment² the proportion of days with colic declines from 86% for the first treatment, through 81% and 79%, to 74% for the last treatment given. There is, therefore, a clear trend of improvement over time so that treatments given first tended to do badly.

The small size of the study also gives cause for concern. The authors conclude that 'infantile colic is not a symptom of lactose malabsorption'. It is doubtful whether the study could have provided adequate statistical power to detect any true differences that may exist. Finally, a repeated measures analysis of these data should have been done, rather than the statistically invalid methods used in the paper.

It is only by an appropriately designed trial using an adequate sample size that the question of an association between cow's milk and infantile colic may be answered.

References

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- ² Pocock SJ. *Clinical trials: a practical approach*. Chichester: John Wiley & Sons, 1983.

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