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Professor Hughes and Dr Long comment:

We were interested to read of Dr Schober's experience of using the Insufion cannula in 49 young diabetics. The circumstances in which he used the device were entirely different to those operating during our study. The comparison is therefore not a valid one other than to comment that the device did not appear to be either effective or acceptable when tried out in a summer diabetic camp setting. We did have problems ourselves until we learned how to apply consistently the adhesive patch, such that our diabetic children were then able to participate in a wide range of activities.

We re-emphasise the value of this type of indwelling cannula device for the admini-stration of insulin to newly diagnosed diabetics and for those children with needle phobia. Clearly, further studies are required to deter-mine whether such a device would be of practical benefit in a wider range of circum-stances.

γδ T cells in human breast milk

SIR,—We previously reported that the pro-portion of lymphocytes bearing the γδ T cell receptor is significantly higher in human colostrum than in either autologous or hetero-logous blood samples.¹ Additional studies revealed that the great majority of colostrals γδ T cells react with a monoclonal antibody (δTCS1) which recognises actively motile cells that express non-covalently bound γδ chains.² To characterise further the phenotype of this small, but numerically important, T cell subset, we have now examined eight milk lymphocyte suspensions with a more complete panel of monoclonal antibodies directed against T cell related antigens.

Direct and indirect immunofluorescence staining techniques followed by two colour cytofluorimetric analysis showed that only a few (15–35%) milk γδ T cells (TCR δ1⁺) were CD8⁺, whereas nearly all were CD4⁺, CD5⁺, and CD7⁺. In contrast, an over-whelming preponderance (85–95%) of colostrals γδ T cells displayed the HML–1⁺ phenotype. This is the reverse of situation encountered in the bloodstream, where HML–1⁺ T lympho-cytes are virtually absent.

Although the origin of colostrals T cells is still a matter of conjecture, the fact that the phenotypic pattern of milk γδ T lymphocytes is similar, if not identical, to that of the intestinal intraepithelial counterpart³ suggests that these cells might originate in the gut associated lymphoid system and home to the mammary gland late in pregnancy and throughout lactation. This selective homing process by immune system cells has been well documented in experimental animal models.⁴

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HML–1 monoclonal antibody was kindly supplied by Dr N Cerf-Bensussan, INSERM U132, Hôpital des Enfants Malades, Paris, France.

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Segmental colonic transit time in Duchenne muscular dystrophy

SIR,—We read with interest the recent paper by Korman *et al* concerning the orocaecal transit time in Duchenne muscular dystrophy.¹ In contrast to reports of gastric hypomotility and intestinal pseudo-obstruction, the authors found a normal orocaecal transit time. There-fore the genesis of patient's constipation is not due to impaired small bowel motility. Colonic motility had not yet been studied in Duchenne muscular dystrophy.

For this reason, we recently studied segmental colonic transit time in 12 patients, aged 8 to 18 years (mean 12.3 years). Eight of them were confined to a wheelchair. Gastro-intestinal symptoms were noted and segmental colonic transit time was performed according to a method previously described²: 20 markers were given at breakfast time to the patients for three consecutive days and plain film of the abdomen was taken at the fourth and seventh days.

Ten children had at least one criteria of constipation: less than three stools per week (n=5), difficulties in defecation (n=7), and hard stools (n=3). Ten had gastrointestinal symptoms: abdominal pain (n=7) proctologic abnormalities (n=5), encopresis (n=2), and abdominal distension (n=2). Results of segmental colonic transit time are reported in the table. Seven of 12 children with Duchenne muscular dystrophy had an abnormal colonic transit time: three had stagnation of markers in the rectosigmoid area and four had an abnormal transit time in all the colonic segments. No relationship was found between colonic transit time and either gastrointestinal manifestations or gravity of muscular dys-trophy.

Our results show that impairment of colonic transit time is frequent in Duchenne muscular dystrophy. Immobility, weakness of abdominal wall muscles and smooth muscle involvement

of the colon⁴ might explain the high frequency of constipation in these patients.

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Surfactant treatment for premature babies—a review of clinical trials

SIR,—In the review article on surfactant treatment,¹ Surfactant (Abbott Laboratories) is described as a frozen aqueous suspension. The current formulation of Surfactant, recently approved for commercial use in the United States, is a suspension requiring refrigeration only. Before administration, Surfactant vials are warmed to room temperature.

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1 Morley CJ. Surfactant treatment for premature babies—a review of clinical trials. *Arch Dis Child* 1991;66:445-50.

Paediatric Laboratory Medicine Fund of the Royal College of Pathologists

SIR,—Funds have been made available to promote scientific interchange in all branches of paediatric laboratory medicine in the UK.

Segmental colonic transit time in 12 patients with Duchenne muscular dystrophy

Age (years)	Right colon* (hours)	Left colon* (hours)	Rectosigmoid* (hours)	Total*	Constipation	Other gastro-intestinal symptoms
8	6	1	13	20	+	+
9-5	2	1	41	44	–	+
10	30	35	10	75	+	+
11	14	6	8	28	+	+
11	2	1	28	31	+	+
12	24	20	41	85	–	+
13	12	14	47	73	+	–
14	1	11	29	41	–	+
14	13	1	41	55	+	–
15-5	59	61	0	120	+	+
16	4	4	30	38	+	+
18	50	37	7	94	+	+

*Upper limits of normal range of colonic transit time in French children are right colon, ≤18 hours; left colon, ≤20 hours; rectosigmoid, ≤34 hours; and total, ≤62 hours.³ Abnormal values underlined. Plus (+) and (–) signs indicate present or absent.

The fund is administered by a committee which is chaired by Professor Dame Barbara Clayton. Applications for grants for the following purposes will be considered: (1) to help laboratory workers to attend meetings in the UK or abroad. (2) To support the travel of laboratory workers to recognised institutions to learn techniques. For the latter purpose priority would be given to applications from junior workers. (3) To support meetings on paediatric laboratory medicine in the UK. The support could be: (a) a contribution to a meeting on paediatric laboratory medicine or (b) sponsorship of a special lecture or session relevant to paediatric medicine organised as part of a larger meeting.

For further details and application form please write to me, Fund Secretary, at the address shown below.

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AUTUMN BOOKS

Whenever I read a book review I am reminded of my guilty secret: as a clinical student I spent not a penny on textbooks, excluding the 7/6d demanded by my medical school library to replace a copy of *Aids to Anatomy* stolen by an expectant, but doubtless disappointed, burglar.

My guilt is not because I am afraid I might be ill informed but because authors deserve better than to have their work unrecognised. The only way to assuage it is to persuade others to read while begging and borrowing cash to replenish the ward library. There is no longer any time to wade personally through a textbook, unless it be about resource initiatives or contracting; it may not even be necessary to read these if you borrow your infant child's copy of Andersen's *The Emperor's New Clothes*.

Those whom I most frequently try to persuade are the senior house officers. All of mine are expected to become general practitioners. It has long been a custom of that trade to demand assessments of its trainees which are in strict non-confidence. Many of us find it awkward to criticise in print a senior house officer who will remain working with us for several months. After a time I become ashamed of my own euphemisms but at least there is one area where criticism can be unbounded. One of the standard assessment questions refers to the trainees' reading habits. One cannot know what goes on in the privacy of their hospital cells between bleep calls but I doubt if much serious reading goes on except in preparation for diploma exams.

Before they leave for the outside world I suggest four books in which they should invest personally. Firstly, a large multiauthor textbook to keep at the phoneside so that as general practitioners they can be one step ahead of their patients or as registrars, of their house officers. Whether homegrown or trans-

atlantic I leave to their whim. Secondly, now that many postparturients stay in hospital for so little time a pocket neonatal paperback is vital. Thirdly, a work that details useful practice in screening and surveillance which, I should point out, will pay for itself many times over—financially as well as sapientially. Finally, and this is the one I will breathlessly tell Sue Lawley will accompany me to my island retreat, no-one should practice children's medicine without a copy of the late Ronald Illingworth's *Common Symptoms of Disease in Childhood*.

HARVEY MARCOVITCH
Consultant paediatrician

Recent Advances in Paediatrics 9. Edited by T J David. (Pp 256; £19.95 softback.) Churchill Livingstone, 1990. ISBN 0-443-04304-3.

For practical purposes medical knowledge is now infinite and has a half life of about a decade. The central dilemma for its disciples, therefore, especially in as wide a discipline as paediatrics, is to keep abreast of the knowledge they need. Many scan the periodicals with remarkable diligence but much of their content is merely the gossip of medical science and shrinks to invisibility when the necessary correction factor for contemporary research is applied. Others have faith in the electronic revolution and can absorb only preprocessed byte sized morsels but these will remain digestible only to addicts until our race evolves a serial or parallel port. The best medium for conveying knowledge and stimulating thought is the short essay reviewing a topic on which the author has thought long and hard and has sifted and organised the knowledge available. A collection of such essays should be well printed, light enough for the lap, cheap enough for the pocket, and enclosed in a fluid resistant cover. This volume meets these preliminary criteria, so what of the contents?

There are 12 essays covering bacterial meningitis, primary immunodeficiency, constipation, short stature, diabetes mellitus, developments in ear, nose, and throat surgery, infants of drug dependent mothers, the thermal environment of sleeping babies, the symptoms and signs of illness in infants, respiratory distress syndrome, support after sudden infant death, and cows' milk allergy. In a final chapter, the editor adds a brief telegraphic review of the paediatric literature of 1989.

This is a good selection, including six general paediatric and six neonatal/infantile topics and apparently working on the principle of something old, something new, but nothing blue. It is a relief to be given respite from consideration of deliberate abuse of children but there are more surprising omissions. *Nothing* on genetics?! It seems at first the biological revolution has been completely ignored but, turning to the index with bated breath, there is a single reference to DNA probes.

Reflecting the principles stated above, those essays that review and update an important topic are most enjoyable and instructive. Most of these have been reviewed many times before, often by the same authors, and there is a risk of battle fatigue when old and tried warhorses are wheeled into the front line yet again. However, a discerning editor such as Dr David can judge who is not yet due for the knacker's yard. An exemplary chapter is that

by Levin and Heyderman on bacterial meningitis, in which old knowledge is consolidated and recent advances are critically appraised in the space of 19 pages. The essays on recent work are also valuable but are likely to need substantial revision in subsequent volumes. The terminal literature review seems too personal and already too dated to justify a place in such a collection.

This volume is a worthy successor in a distinguished line. Annual publication is now planned and will be warmly welcomed if such a high standard can be maintained. Paediatricians should buy the book and make time to enjoy it a chapter at a time, but beware the advice of John Dryden to '... make a short essay, then hasten to get drunk, the business of the day'.

NICK BARNES
Consultant paediatrician

Constipation in Childhood. By Graham Clayden and Ulfar Agnarsson. (Pp 123; £9.50 paperback.) Oxford University Press, 1991. ISBN 0-19-262027-4.

Despite all the recent advances in the management of childhood disorders, constipation remains very much part of the bread and butter of paediatrics, both in general practice and the hospital setting. Unfortunately, it is often inadequately or poorly treated with resultant distress for the child and family.

The aim of this book is to assist paediatricians, family doctors, and others involved in the management of children with constipation. The book starts by going into the anatomy of the anorectum and physiology of anal continence and defaecation, thus providing a scientific basis for the management strategies of constipation. This is followed by a discussion of constipation in babies, toddlers, and older children and the special problems of children with disabilities.

Most children with constipation do not require extensive investigations and therefore, quite appropriately, the chapter on the medical management of constipation precedes that on investigations. Surgical treatments are briefly discussed followed by a chapter on psychological management. The final section of the book consists of a booklet designed to be photocopied and given to parents and children.

The practical and logical approach to constipation set out by the authors should make this book compulsory reading for anybody involved in the management of constipation in childhood. It is relevant to health visitors and general practitioners, as well as paediatricians. Added attractions are the parents' booklet and the very reasonable price of this book. I would recommend that every paediatrician and general practitioner should purchase this book.

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The Multi-Professional Handbook of Child Sexual Abuse. By Tilman Furniss. (Pp 357; £20 paperback.) Routledge, 1991. ISBN 0-415-05563-6.

Begin this book at the beginning. Start with the introduction where Professor Furniss warns of part 1, it 'may be difficult and dry reading'. He advises the reader to look up