Drs Ogilvy-Stuart and Shalet suggest that our results indicate a sexual dimorphism in thalassaemic children in terms of persistence of gonadotrophin deficiency secondary to iron deposition in the pituitary. The aim of our study was to assess whether conditioning treatment before bone marrow transplantation (BMT) with busulphan and cyclophosphamide may cause gonadal damage in thalassaemic patients, which would have a deleterious effect on the quality of life. While our data did not demonstrate obvious gonadal damage in prepubertal boys, it did so in girls. As a consequence, the discussion was focused on this last aspect, which was crucial to the aim of the study. However, we did recognise the possibility that the reduced gonadotrophin response after gonadotrophin releasing hormone in prepubertal thalassaemic males may be a consequence of iron overload which could conceal germinal epithelial damage. There is no doubt that long term follow up studies are necessary to demonstrate if the gonads of male thalassaemic patients are damaged by cytotoxic drugs.

This possibility is an additional reason for considering gonadal damage when discussing the pros and cons of BMT and this aspect was emphasised in our discussion. We agree that the patterns of gonadotrophin in response to gonadotrophin releasing hormone, found in prepubertal thalassaemic males, seems to suggest a higher sensitivity to iron overload. However, we feel that other studies must be made to explain this dimorphism in thalassaemic patients, because this hypothesis is not supported by the findings of a multicentre study on endocrine complications in 3200 thalassaemic patients followed up in 41 Italian hospitals. The result of our survey has shown an absence of puberty in 41% of the males and 39% of the females, over the age of 15 years (V De Sanctis *et al*, unpublished data).

We thank Drs Ogilvy-Stuart and Shalet for pointing out that the serum testosterone values reported in table 2 and in the text are not correct. We are very sorry for this mistake, which was caused by the change made from ng/ml to nmol/l. The values given should be reduced by a factor of 100.

Equipment requirements for community based paediatric oxygen treatment

SIR,—The bare list of ingredients required for domiciliary oxygen treatment is of little value without accompanying instructions on how they should be assembled.¹ Deficiencies in the current system of provision for community based oxygen treatment need to be tackled by national recommendations and the provision of appropriate devices for young children on prescription.

To this end, a Working Party on Domiciliary Oxygen Therapy for Children was convened under the auspices of the Committee for Thoracic Medicine of the Royal College of Physicians (London) in order to provide the Department of Health with the concerted recommendations of a number of organisations. It met in January and its recommendations have been submitted to the Department of Health.² Briefly the document recommends the types of equipment that are needed, the means whereby the equipment should be supervised, and the level of clinical support for families receiving domiciliary oxygen treatment. The responsibilities of health professionals within and without the hospital and

the role of the equipment industry were addressed.

It is hoped that these recommendations will provide the basis for the provision of domiciliary oxygen treatment for children to match the system which has evolved over a number of years for adults with chronic obstructive airway disease.

MICHAEL SILVERMAN
Chairman of the working party,
Department of Paediatrics and Neonatal Medicine,
Hammersmith Hospital,
Du Cane Road,
London W12 0NN

- 1 Angell C. Equipment requirements for community based paediatric oxygen treatment. *Arch Dis Child* 1991;66:755.

*Members of the working party represented: Royal College of Physicians, Royal College of General Practitioners, Medical Gases Industry, Cystic Fibrosis Trust, British Paediatric Association, British Association of Perinatal Medicine, Royal College of Nursing, Department of Health, and British Thoracic Society.

Copies of the recommendations are available from Dr Silverman on receipt of an A5 stamped, addressed envelope.

Computerised information systems

SIR,—I read with interest Dr Spencer's recent article on neonatal information systems.¹ While admirably covering a large topic in a few pages, there were two points that I feel warrant greater emphasis.

'Local' databases that are set up by enthusiasts—and I have been involved in four such systems in different hospitals—often fall into relative or absolute disuse after a period of time. While this may be due to fundamental weaknesses in the systems, it is more commonly due to one of two factors.

Firstly, the enthusiast who initiated the project may well move to a different hospital. This leaves a void, often with direct control passing to someone who was not immediately involved in the development. Any problems that later arise (and they will!) may be difficult to fix, and further development of the system often ceases.

Secondly, and associated with the first point, is the importance of clear documentation. Dr Spencer mentioned this in his last sentence as 'an asset', but this understates its crucial role. Interest in the database is likely to wax and wane with time, as workload alters, research fellows come and go, or as the deadline for yearly reports comes round. Without comprehensive and clear documentation for a system, including details of trouble shooting and support available, the system will gradually deteriorate. Clear manuals must be an essential aspect of any computerised system.

R I ROSS RUSSELL
Department of Child Health,
King's College Hospital,
London SE5 9P3

- 1 Spencer SA. Computerised neonatal information systems. *Arch Dis Child* 1991;66:823–6.

Septicaemia and adrenal haemorrhage in congenital asplenia

SIR,—The incidence of congenital absence of the spleen is said to be one in 2000, according

to the one postmortem series.¹ Dyke *et al* report five cases of asplenia including two otherwise normal infants.² We have recently seen a 1 year old infant who, in his first year of life, has had pneumococcal meningitis twice and osteomyelitis (culture negative) once. Several ultrasound scans and a technetium labelled sulphur colloid scan failed to reveal a spleen. Numerous Howell-Jolly bodies were present in the erythrocytes. He has no other apparent congenital abnormalities; immunoglobulin, white cell, and complement studies are normal. We concur with Dyke *et al* that congenital asplenia is an under recognised entity, and recommend the use of pneumococcal and *Haemophilus influenzae* vaccine at diagnosis, despite the lack of demonstration of efficacy in infants less than 24 months. The potential benefits of vaccination appear to outweigh possible adverse effects. Surely these infants need not wait until aged 18–24 months for potentially preventive immunisation?

DENIS G GILL
MAJDI KARA
The Children's Hospital,
Temple Street,
Dublin 1,
Republic of Ireland

- 1 Shinohara Y, Komiya S, Nakashima A, *et al*. Asplenia and polyplesia syndrome. *Acta Pathol Jpn* 1982;32:505.
- 2 Dyke MP, Martin RP, Berry PJ. Septicaemia and adrenal haemorrhage in congenital asplenia. *Arch Dis Child* 1991;66: 636–7.

SIR,—I read the paper by Dyke *et al* illustrating the role of *Haemophilus influenzae* infection and adrenal haemorrhage in causing overwhelming infection and death in patients with congenital asplenia with great interest.¹ I would like to bring to the attention of your readers a further case that recently presented to the Adelaide Children's Hospital.

Case report

A white girl aged 2 months was taken late at night to a country hospital with a three day history of breathing difficulties and cough. Apart from a non-prescription cough medicine no other medication had been given before admission. The initial examination showed that she had a temperature of 38°C and was tachypnoeic with laboured respirations. A provisional diagnosis of pneumonia was made and a single dose of intramuscular penicillin was given. After admission she appeared to settle initially but was found dead in bed four hours later. Her body was transferred to the Adelaide Children's Hospital for postmortem examination with a provisional diagnosis of death from pneumonia or possible sudden infant death syndrome.

At postmortem examination there was situs inversus of thoracic and abdominal organs with dextrocardia but no other significant cardiac abnormality. There was no spleen but two splenunculi (combined weight 3.4 g) were found in the right upper quadrant. Both adrenal glands were appreciably haemorrhagic. The lungs were atelactatic but there was no evidence of pneumonia. Bilateral otitis media was evident. Microbiological cultures including blood culture and culture of lung and middle ears were negative, but penicillin given before death may well have eliminated a sensitive organism.

This case further emphasises the points made by Dyke *et al* of the need to look for