endotoxin damages the cochlea, children with meningococcal disease would be a suitable population to study. Children present predominantly with septicaemia, meningitis, or a mixed picture of septicaemia and meningitis.³ Deafness in survivors of fulminant septicaemia, meningococcaemia without meningitis, and meningitis alone might be commoner in all groups than in a control population. A case-control follow up study of a cohort of children with meningococcal disease would answer this question.

The practical conclusion of such a study might be that clinicians should be ordering routine audiological follow up for patients with meningococcal septicaemia, as well as for those with meningitis.

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- 1 Tarlow MJ, Comis SD, Osborne MP. Endotoxin induced damage to the cochlea in guinea pigs. *Arch Dis Child* 1991;66:181-4.
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Head injury—how community paediatricians can help

SIR,—Head injury must be the major health issue among children in the United Kingdom, accounting for 15% of deaths in children aged 1-15 years.¹ However, we question the admission rate of 45 per 1000 children per year after head injury quoted by Dr Crouchman in her recent article.² We have recently conducted a retrospective review of all children aged less than 16 years who died or were admitted to hospital after head injury in the Northern region during the eight year period 1979-86.^{1,3,4} During this period head injury was the single major cause of admission to hospital, however, the annual admission rate was only a tenth of that quoted by Dr Crouchman, being 4.9 per 1000 children. In view of the importance of accurate epidemiological data in planning services for head injured children, we believe that it is imperative that this issue is clarified.

We would also like to suggest that community paediatricians should have a leading role in the prevention of head injury and not confine their activities simply to the provision of rehabilitation services. The recent evidence that serious head injury occurs more frequently at particular times of day and in areas of high material deprivation⁵ should surely stimulate community paediatricians to take the lead in initiating appropriately targeted preventive measures.

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- 1 Sharples PM, Storey A, Aynsley-Green A, Eyre JA. Avoidable factors contributing to death of children with head injury. *BMJ* 1990;300:87-91.
- 2 Crouchman M. Head injury—how community paediatricians can help. *Arch Dis Child* 1990;65:1286-7.
- 3 Sharples PM, Storey A, Aynsley-Green A, Eyre JA. Causes of fatal childhood accidents involving head injury in the Northern region, 1979-86. *BMJ* 1990;301:1193-7.
- 4 Sharples PM, Aynsley-Green A, Eyre JA. The management of children with head injuries in district general hospitals. *Arch Dis Child* 1988;63:570.
- 5 Kraus JF, Rock A, Hemyari P. Brain injuries among infants, children, adolescents and young adults. *Am J Dis Child* 1990;144:684-91.

Dr Crouchman comments:

I must thank Drs Sharples and Eyre for pointing out the typing error in the first sentence of my paper. It should, of course, have read 45 per 10 000 children per year.

I agree that there is an important role for the consultant community paediatrician in the prevention of childhood accidents. My own view is that health education has only a limited place, and that every district needs a multi-agency group with the teeth to influence local housing, street planning, and the provision of safe play space.¹ It would seem very appropriate that consultant community paediatricians should contribute to this group as part of their essential public health function.²

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Doppler assessment of pulmonary artery pressure in acute phase of hyaline membrane disease

SIR,—I read with interest the paper by Evans and Archer.¹ The study is well described with clear presentation of results.

I would, however, take issue with the definition of right ventricular ejection time (RVET). The authors define RVET as the time interval between the systolic waveform leaving its peak velocity and returning to the baseline. The total RVET is more appropriately defined as the time from the onset of ejection to that of zero flow. The latter definition is that used by Kitabatake *et al* and this is the main reference article by the authors.²

Any error in the measurement of total RVET will be reflected in the ratio time to peak velocity: right ventricular ejection time (TPV: RVET). The ratio as defined by Kitabatake *et al* was shown to have a linear inverse relationship to log₁₀ of the mean pulmonary artery pressure.² Any relationship to pulmonary artery pressure by the ratio TPV: RVET as described by the authors has not been verified.

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- 1 Evans NJ, Archer LNJ. Doppler assessment of pulmonary artery pressure and extrapulmonary

- shunting in the acute phase of hyaline membrane disease. *Arch Dis Child* 1991;66:6-11.
- 2 Kitabatake A, Inoue M, Asao M, *et al*. Non-invasive evaluation of pulmonary hypertension by a pulsed Doppler technique. *Circulation* 1983;68:302-9.

Drs Evans and Archer comment:

We are grateful to Dr Craig for drawing our attention to an error in the text which we failed to notice at proof reading. The correct definition of right ventricular ejection time (RVET) and the one which we did indeed use is shown in the following phrase which is a corrected version of the text: 'RVET was the time interval between the systolic wave form leaving and returning to the baseline'. This is consistent with Dr Craig's definition.

Photic sneezing

SIR,—Photic sneezing is well documented in the ophthalmological¹ and neurological² literature. Light induced sneezing appears to be more common in male than female, white than black, and in those with a positive family history. Photic sneezing, an uncontrollable paroxysm of sneezing provoked by sudden exposure to intense bright light, is an occupational hazard for the ophthalmologist.

An enhanced photic sneeze reflex has recently been reported in patients with cystinosis.^{3,4} The mechanism of the reflex is obviously complex involving optic, oculomotor, and trigeminal nerves, autonomic pathways, and central brainstem structures. I am a 'sufferer' from photic sneezing, which is most noticeably inconvenient when driving into bright sunlight, and I have two boys who also demonstrate the reflex. I note, with interest, how frequently I have observed the reflex in babies.

I wonder about the evolutionary process behind this bizarre reflex? The reflex appears to be less marked as the child matures. Is this because it serves no useful purpose and is a 'vestigial' reflex?

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- 1 Lewkonia I. An infrequent response to slit lamp examination. *Br J Ophthalmol* 1969;53:493-5.
- 2 Everett HC. Sneezing in response to light. *Neurology* 1964;14:483-90.
- 3 Smith R. Editorial. *Br J Ophthalmol* 1990;74:705.
- 4 Katz B, Melles RB, Wenson MRS, Schneider JA. Photic sneeze reflex in nephropathic cystinosis. *Br J Ophthalmol* 1990;74:706-8.

Duplicate publication

SIR,—I read your recent editorial on duplicate publication with interest and some wry amusement.¹ This is not a new problem and has exercised the minds of editors of general as well as specialist journals.² It is surprising that the editors, all distinguished clinicians, should after an accurate diagnosis spend their efforts discussing control of symptoms with no reference to treating the underlying cause.

Clinicians will continue to submit multiple papers so long as appointment boards contain individuals who believe that a doctor who has published 10 papers must be twice as good as one who has published five. Why a good clinician, who wishes to practice as such,