

**Hyperoxaluria in children with hepatic and intestinal dysfunction.** J. P. K. McCollum, S. Packer, J. Manning, and J. T. Harries. The Hospital for Sick Children, Great Ormond Street, and Institute of Child Health, London, W.C.1.

The association of hyperoxaluria and renal oxalate stones has recently been reported in adults after small intestinal resection; the hyperoxaluria may be related to disturbances of bile salt metabolism. We have determined urinary oxalate excretion in a total of 43 children who fell into the following groups. *Group A*, 11 normals; *group B*, 3 with primary hyperoxaluria and renal stones; *group C*, 6 with small intestinal resection; *group D*, 8 with liver disease; *group E*, 15 with a variety of other malabsorptive states. The mean (and range) values for urinary oxalate expressed as mg/24 hr per  $1.73\text{m}^2$  for groups A, B, C, D, and E were 23.6 (16.1–30.6), 107.2 (100.0–119.7), 35.1 (20.4–58.4), 52.3 (34.8–88.8), and 35.4 (9.9–67.0), respectively. 2 patients in group C, 6 in group D, and 8 in group E had increased urinary oxalate excretion. These results indicate that hyperoxaluria may not be an uncommon feature in a variety of hepatic and intestinal diseases in childhood, and may have important implications.

**Serum and erythrocyte folate levels in low birthweight infants.** A. P. Kenna and E. D. Hibbard

introduced by L. Rosenbloom. Alder Hey Children's Hospital, Liverpool.

**Fits in hydrocephalic children.** G. P. Hosking. National Hospital for Nervous Diseases, London. Published in full in the *Archives*, **49**, 633.

**Patterns of infant feeding in Oxford.** K. Sloper and D. Baum. Department of Paediatrics, John Radcliffe Hospital, Oxford.

A survey was made of babies discharged from a busy maternity ward over a period of 20 weeks. Information was collected on whether the babies went home breast feeding or bottle feeding, or both. A follow-up study was made by questionnaire. Data were collected on the time of change from breast to bottle feeds, the time of introduction of solids, the age, parity, social class of mother, how mother herself was fed in infancy, and the influence exerted by various health authorities (including grandmothers) on these patterns of infant feeding. The most striking conclusions were the low rate of breast feeding on discharge from hospital (around 30%); of those discharged breast feeding, the rapid change to bottle feeds over subsequent weeks (35% by 1 month); and the rapid introduction of solids whether the babies were bottle or breast fed at home (15% by 1 month, 60% by 2 months).