prognosis of the condition. In addition, birth asphyxia is potentially avoidable and the importance of initial resuscitation in infants at risk of developing the respiratory distress syndrome has been stressed.

**Recognition of hypertrophic obstructive cardiomyopathy in childhood.** G. I. Fiddler (introduced) and M. J. Godman (introduced). Royal Hospital for Sick Children, Edinburgh.

Recent studies of hypertrophic obstructive cardiomyopathy have suggested that this is a familial condition transmitted as an autosomal dominant trait and may be associated with a poor long-term prognosis. The clinical diagnosis can be made in childhood in the presymptomatic phase, but may be difficult. 8 children with the condition between the ages of 1 and 13 years who were referred for evaluation of a late systolic murmur were discussed. Only one patient had symptoms. The clinical findings and electrocardiographic appearances in 5 suggested that the probable diagnosis was cardiomyopathy. In the remaining 3 the murmur was not thought to be diagnostic, and the electrocardiograms were normal. In 6 of the 8 patients cardiac catheterization and angiography confirmed the diagnosis. In all 8 patients, however, echocardiography showed the typical features of hypertrophic obstructive cardiomyopathy with asymmetrical hypertrophy of the interventricular septum and abnormal midsystolic reopening of the mitral valve. These observations confirmed that echocardiography is a valuable technique in the diagnosis of hypertrophic obstructive cardiomyopathy in childhood. Because it is non-invasive, the technique can be used to screen families of index cases.