Correspondence

A suggested child-health clinic form

Sir,

I read with interest the paper by Professor Illingworth (*Archives*, 1979, 54, 626). The format is clear and concise, and the columns for 'normal', 'doubtful', 'abnormal', and 'why the finding may be abnormal' are practical and serve to emphasise the author's oft repeated warning of the fallacies of a figure for an overall score. The list of risk factors, similar to that used in an earlier record card designed by a subcommittee of the BPA and the (then) Society of Medical Officers of Health, has proved invaluable.

My main points of criticism are:

(1) The omission of tests for distant and near vision in infants from 6 months. Two of the important questions asked of developmental assessment are, 'Can he hear?' and 'Can he see?'. Child health doctors have become increasingly aware of the need to attempt to answer the former but still require guidance to learn to use Stycar tests of vision, admirably designed by Mary Sheridan. The visual experience of young children plays an important part in early learning. Poor visual acuity is not necessarily associated with nystagmus, opacity, or persistent squint and may be missed unless tests for vision are done routinely.

(2) The development of prelanguage and early language skills is of special importance from 9 months. By 2 years the child's personality is becoming more integrated and any unevenness between performance and language skills may be significant. A simple heading 'Speech' is inadequate in this context. The whole cognitive development of the child is closely bound up with the ability to communicate in spoken language. There are many reasons why a child may ultimately fail to develop expressive speech. The child health doctor must learn to think of language development in terms of comprehension, symbolisation, and expressive speech if effective intervention programmes are to be introduced early.

(3) The subheading 'Developmental examination only if necessary', from 2 years, is difficult to interpret and appears contrary to the aim for periodical developmental assessment of all young children.

There is little doubt that a well-designed record form can offer helpful guidance and contribute to a rise in the standard of the service itself. Professor Illingworth has offered a design which goes some way towards this objective.

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Professor Illingworth comments:

I am pleased to have Dr Egan's observations. The omission of tests for distant and near vision in infants was deliberate. I should like to know what is to be gained by the tests recommended by Dr Egan when there is no squint, opacity, or nystagmus, and when it is clear from watching the child reach out and grasp small objects that there is no significant treatable visual defect.

Regarding the heading 'Speech', I should like to see a clear statement of the 'effective intervention programmes' advised by Dr Egan for a child, starting to speak later than usual and who has been properly tested for a hearing defect, with the evidence for the effectiveness of that programme.

I agree that the words 'developmental examination only if necessary' should be changed.

I should emphasise that in a busy clinic (like mine where, single-handed, I see at least 40 babies in an afternoon session) one must be sensible and perform only the tests which are useful and important. If the routine rapid screening reveals some doubt about normality, detailed examination of visual or other functions is essential and then one may have to devote an hour or more to a single child.

Dr Irene Chesham has pointed out a significant omission on the suggested chart; a test for phenylketonuria should have been included.

The form was intended to be for consideration, and I shall be grateful for all constructive criticism.

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Wilson's disease, chronic copper poisoning, or Indian childhood cirrhosis?

Sir,

In 1973, the case was described of an Australian boy who presented at age 14 months with abdominal distension.¹ He was found to have a micronodular cirrhosis, renal tubular aminoaciduria, and anaemia. He became jaundiced and died 6 weeks later. Histological examination of the liver showed continuing parenchymal destruction, no regeneration, cytoplasmic hyaline changes, and copper storage. The necropsy hepatic copper concentration exceeded 3000 µg/g dry weight; 47 µmol/g (normal range 15-55 µg/g; 0.24-0.87 µmol/g).

Had this been a Hindu child living in India, his clinical features would have been regarded as typical of Indian childhood cirrhosis (ICC), in which condition hepatic