British Paediatric Association

Proceedings of the Fifty-second Annual Meeting

The Annual Meeting of the British Paediatric Association was held at York from 15–19 April 1980. 501 members and 35 associate members attended together with 4 Heinz Fellows, 18 representatives of the German Paediatric Society, and 243 guests. The Windermere Lecture was given by Prof. H Bickel (Universitäts Kinderklinik, Heidelberg).

The Spring Scientific Meeting of the Royal College of Psychiatrists, Child Psychiatry Section, was held at York on 15 April and a joint session with the BPA was mounted on 16 April.

The Annual General Meeting of the British Paediatric Association was held on Thursday, 18 April 1980. The President, Dr G M Komrower, was in the chair. The minutes of the last meeting, which had been published in the Archives of Disease in Childhood, were received and approved.

ELECTION OF OFFICERS. The following will serve the Association for 1980–81.

PRESIDENT: Dr G M Komrower
HONORARY TREASURER: Dr A D M Jackson
HONORARY SECRETARY: Dr D R Harvey
HONORARY ASSISTANT SECRETARIES: Dr J D Baum, Dr D W Fielding, Dr C H Nourse

The following were elected:

MEMBERS OF COUNCIL 1980–1983: Dr W R Forbes, Dr G M Lewis, Dr B McNicholl, Dr M W Moncrieff, Dr G H Watson.

HONORARY MEMBERS: Sir Douglas Black, Dr B Chown, Prof. O H Wolff.

MEMBERS: R S Ackroyd (Birmingham), P J Aggett (Aberdeen), Janet M Anderson (Wolverhampton), I A AUCHTERLONIE (Aberdeen), M F M Bamford (Portsmouth), S M Basheer (Cork), J H Baumer (Bristol), A R J Bosley (Cardiff), I H Brown (Bristol), Judith M Brown (Nairobi), Susan M Brown (Birmingham), T Brown (Dundonald), A M Butterfill (London), R W I Cooke (Liverpool), J F Cosgrove (Waterford), S Court (Nottingham), Colleen A Cox (Hounslow), Mary C Cummins (London), D A Curnock (Derby), Kathleen Dalzell (Wrexham), T J David (Manchester), B Davies (London), Elizabeth Dryburgh (Leeds), Lilly M S Dubowitz (London), D A Ducker (London), Eileen M C Duke (Glasgow), D B Dunger (London), H B ECKSTEN (London), A N Evans (London), D I K Evans (Manchester), Dr G I Fiddler (Leeds), N C Fraser (Edinburgh), Cynthia M Gabriel (St Albans, Welwyn Garden City), A R Gatrard (Oldham), Joan Gray (Aylesbury), J D M Gould (London), T Graham (Wegberg), R Greenham (Manchester), M J Harran (Leicester), I G Hill (Birmingham), Judith Hockaday (Oxford), P Hutchins (London), Audrey J Jones (Bromley), R W A Jones (London), Dorothy V Joss (London), C R Kershaw (Southampton), A D Kindley (Liverpool), Iris G Knight (Brantree), Mary F Knight (St Helens), I Kovar (London), B D Lask (London), T Lee (Bristol, Exeter), W Lenney (Brighton), M J Lewins (Cardiff), Helen Lewis (Manchester), T Lissauer (Harrow), M F Lowry (Birmingham), R C McWilliam (Glasgow), Barbara S M Marshall (Leicester), A J Martin (Newcastle upon Tyne), T G Matthews (Dublin), Marion Miles (London), R A Minns (Edinburgh), Eileen Naughten (Oxford), R Newton (Manchester), Pauline A O’Connell (Dublin), A S Paynter (Newcastle upon Tyne), J L Pearce (Slough), M E Pembrey (London), Betty E Powe (London), M P Prendergast (Norwich), Constance R Pullan (Newcastle), Heather Richardson (Canterbury), R P A Rivers (London), D W Rogers (London), S Rom (London), S A W Salfield (Sheffield), D Salisbury (London), M A A Siddiqi (Newport), N J Spencer (Sheffield), J A Spies (London), C Spratt (St Helier), C R Steer (Edinburgh), C M Stern (London), N Tangey (Dublin), C J Taylor (Liverpool), C M Taylor (Birmingham), M A Tettenborn (London), B Thalayasingam (Consett), Ruth B Thompson (Glasgow), R L Tozer (Richmond), R Tyler (London), Mary J Vaizey (Boston), M P Wailoo (Southampton), Sheila M Wallis (Reading), A R Watson (Manchester), S Williamson (Ashford), R A Wilson (Manchester), Janet G Yassa (Sheffield).

ASSOCIATE MEMBERS: Winifred Bartindale (Dudley AHA), Mary Brayshaw (Calderdale AHA), Kathleen
Campbell (Birmingham AHA), Margaret Carrie (Lothian Health Board), Lydia Cowan (Greater Glasgow Health Board), S G A Dias (Kensington, Chelsea, and Westminster AHA), Isabelle Ellis (City and East London AHA), Margaret Ewart (Lambeth, Southwark, and Lewisham AHA), Mary Gallaher (Greater Glasgow Health Board), Doreen George (Dudley AHA), Doreen Gledhill (Bradford AHA), Eiwen Griffiths (Kent AHA), Ruth Graham-Yoll (Lothian Health Board), Jean Horne (Greater Glasgow Health Board), Margaret Inglis (Greater Glasgow Health Board), Angela Johnston (Essex AHA), Wendy Kemp (Lothian Health Board), Maria Kreppel (Lothian Health Board), Glenys Lowdon (Newcastle upon Tyne AHA), Philippa Ludlam (Lothian Health Board), J McFadden (Greater Glasgow Health Board), Seethadevi Madadeva (Birmingham AHA), Joan Martin (Kensington, Chelsea, and Westminster AHA), Marjorie Masson (Lothian Health Board), Rosemary Meyers (Northern Ireland Eastern Health and Social Services Board), Meryn Pearce (Lothian Health Board), F S Rogers (Northumberland AHA), J W Tuke (Northumberland AHA), Sara Young (Humberside AHA).


1. Obituaries
The Association has suffered the loss of Dr J D Allan, Dr A C Blandy, Prof. Guido Fanconi (Honorary Member), Dr I R S Gordon, Dr A P M Page, Dr R R Struthers, Prof. Jack Tizard (Honorary Member) and Prof. H L Wallace (Honorary Member).

2. Council
Membership. The following members of the Association have served on Council during 1979–80: Dr G M Komrower (President), Dr D P Addy, Dr J D Andrew, Dr E H Back, Dr R D H Boyd (Honorary Assistant Secretary), Prof. F Cockburn, Dr A F Conchie, Dr W Davies, Prof. E E Doyle, Dr J P Harper, Dr D R Harvey (Honorary Secretary), Dr A D M Jackson (Honorary Treasurer), Dr B W Lewis, Dr M M Liberman (Honorary Assistant Secretary), Dr J M Littlewood, Dr D Morris, Dr C H Nourse (Honorary Assistant Secretary), Dr Aileen Redmond, Dr L Rosenbloom, Dr N J Royston, Dr M J Simpkins, Dr H Simpson, Dr P E Walker, Dr S G F Wilson, Dr B Wolman, Dr H B Valman, Dr M H Bellman (Junior Representative), Prof. D Hull (Chairman of the Academic Board).

Observers. The Association is grateful to the following for assistance and advice both at Council and in many other ways: Prof. F S W Brimblecombe (Member of the Central Health Services Council), Mr A Jolley (President of the British Association of Paediatric Surgeons), Prof. R G Mitchell (Association of Clinical Professors and Heads of Departments of Paediatrics), Prof. T E Oppé (Adviser in Child Health, DHSS), Dr Marie Richards (Welsh Office), Dr Mary Tate (Department of Health and Social Security).


3. Matters Concerning the Administration of the Association
The Association’s staff comprises an Executive Secretary and four Assistant Secretaries. It has been necessary to increase the number of Assistant Secretaries from three to four in order to cover the extra work load created by the new category of Associate Membership and extra representation on outside bodies. A temporary secretary was again taken on for 2 months before the 1980 Annual Meeting to process the booking forms.

The Association would like to record its continuing debt of gratitude to the Institute of Child Health for portering and mailing services, duplicating facilities, and the use of rooms for meetings.

Membership. Council noted that the membership at 9 February 1980 was as follows: Members—962; Honorary Members—110; Associate Members—220.

Academic Board. The 14th Annual Report of the Board has been received by Council.

4. Awards of the Association
James Spence Medal—Prof. J M Tanner.
Guthrie Medal—Dr M A Preece.

Heinz Fellowships of the BPA—Dr M V Joseph and Dr A M Kiango (Fellowship A); Dr P D Manuel and Dr Jean E Shoreland (Fellowship C). In addition a special supplementary award has been made to Dr E W Swaby. The Association remains indebted to the Nuffield Foundation for their advice and administrative help.

5. Finance and Allied Matters
The Directors of Unigate have again generously donated their annual travel grant of £225 and have supplied the programme and stationery for the 1980 Annual Meeting.

A contribution of £100 has been made by Wyeth Laboratories towards the President’s travelling expenses.
A bequest of £500 has been gratefully received by the Association from the late Dr W W Payne towards the promotion of the objects of the Association and in particular to help younger members.

The BPA continues to benefit by a share of the profits from the sale of the *Archives of Disease in Childhood*.

6. MEETINGS OF THE ASSOCIATION
The 51st Annual Meeting of the Association was held at York in March 1979 and 631 members and guests attended. Council wishes to record its appreciation to the Academic Board in organising the scientific programme for these meetings and to thank the many members and guests who submitted papers. Council also wishes to thank the conveners and members of specialty groups (13 of which held sessions during the meeting) for their contributions.

The next Annual Meeting of the Association will be held from 7 to 11 April 1981.

7. STANDING COMMITTEES AND WORKING PARTIES OF THE ASSOCIATION
Reports have been received by Council, and comments have been submitted to government departments and other bodies on many important issues.

Council is deeply grateful to the members who have served on committees and working parties, and also to those who have represented the Association on both statutory and voluntary bodies. Many individual members have helped the Association by their advice, suggestions, and criticisms.

A major change for the Association this year has been the admittance of Associate Members in accordance with the wishes of the Annual General Meeting. Applications were invited and of the 280 who applied 220 were accepted into membership in January 1980. A further 29 were elected at the Annual General Meeting. Two Associate Members were elected at the Annual Meeting to serve on Council.

Council wishes to record its thanks to Douglas Gairdner who retired this year from the Committee of the *Archives of Disease in Childhood*. He had been Editor for 16 years and had always served the Association very well. Prof. Roy Meadow joins Prof. Roger Robinson in editing the *Archives*.

The Association is now being represented on many more bodies either in its own right or through its membership of the Joint Paediatric Committee of the Royal Colleges of Physicians UK and the BPA. There are now paediatric representatives on all three Councils for Postgraduate Medical Education and we are fortunate that the President has been nominated by the Royal College of Physicians (London) to sit on the Joint Consultants Committee. The Association is being consulted more and more about important matters and there has been the opportunity for the Association to be represented at many more meetings. The Association is particularly pleased at the number of times it has been consulted by the DHSS.

Other agenda items
1. The Honorary Treasurer's verbal report and the accounts for 1979 were accepted. The meeting noted that it would be necessary to increase the membership subscription rates from 1 June 1981 in order to keep pace with inflation.

2. The meeting approved the revised rules of the Association circulated to members in December 1979.

3. Dr James Taylor announced that the First World Congress of Paediatric Cardiology would take place from 2 to 6 June 1980 in London.

4. The Honorary Secretary reminded members that in 1982 the Annual Meeting would take the form of a joint meeting with the Scottish Paediatric Society. It would be held in Aviemore from 20 to 24 April. The cost of attendance at the meeting would be greater than at present as hotel accommodation would have to be used.

SCIENTIFIC PROCEEDINGS

WINDERMERE LECTURE. The lecture was delivered by Prof. H Bickel of the Universitats Kinderklinik, Heidelberg, on ‘Inborn errors of metabolism: prevention and treatment’.

Schizoid personality in childhood. S Wolff and J Chick (Edinburgh).

In the treatment of disturbed children and their parents it is important to be accurate in one's aetiological assumptions and to be realistic about a child's capacity for change. Neither child nor parents can be helped if constitutionally based behaviour difficulties are attributed to family pathology or if expectations for conformity remain high in
the face of a child's inherently limited capacity for adaptive behaviour.

Relief and improved behaviour often follow when the psychiatric disorder is correctly interpreted as a result of the child's personality make-up, and allowances are made for him both at home and at school.

One type of personality disorder recognisable in middle childhood is schizoid personality (described by Asperger as schizoid psychopathy of childhood).

This contribution will report on the validation of the syndrome by means of a follow-up study by an independent psychiatrist of 22 schizoid children and 22 controls some 10 years after their original referral to a child psychiatric clinic. At follow-up, the diagnosis of the independent psychiatrist agreed very well with that made in childhood and most of the core features postulated as characteristic of schizoid personality differentiated significantly between the probands and the controls.

A psychiatrist in a paediatric diabetic clinic. M Lindsay, J D Baum, and A L Kinmonth (Oxford).

The incidence of psychiatric disturbance and psychosocial problems in a population of diabetic children is no different from normal children. However it is important to detect and assist with emotional problems in diabetic children because distress directly affects glucose homeostasis in addition to disturbing the child's ability to adapt to his lifelong condition.

An analysis has been made of cases seen by a child psychiatrist attending a weekly paediatric diabetic clinic for a year when 142 families were seen. The presence of a psychiatrist enabled staff to develop a more perceptive and broader therapeutic approach. Specifically the psychiatrist's involvement in clinical consultation was subdivided as follows:

36 families: joint consultation in clinic concerning problems brought by the family or identified by staff: e.g. not eating prescribed food, reflecting family tensions unrelated to diabetes.

11 families: separate consultations in clinic following identifying of serious problems: e.g. two potential suicides (aged 8 and 18).

5 families: problems requiring discussions with staff after clinic: e.g. father obsessionally involved with daughter's diabetes.

2 families: problems were so profound that unless continuous emotional support was assumed, it was felt better not to initiate discussions unless instigated by the family: e.g. father diabetic, blind, and dying from diabetic nephropathy.

88 families: no indication for psychiatric contribution.

Sexually-abused children—are they seen by paediatricians and child psychiatrists? A Bentovim, P Beezley-Mrazek, and M Lynch (London and Denver, USA).

Sexual mistreatment of children is gradually being recognised as a form of child abuse. We hoped to find out who was providing help for these children and their families. Samples of relevant professional groups were circulated with questionnaires to investigate this, providing a categorisation of sexual abuse—such as the battered child with injuries in the genital area, incest, sexual assault, and involvement in pornography.

As one would expect, a comparatively large number of children were being seen by police surgeons. Possibly reflecting society's preoccupation with the perpetrator, few of them were referred for specialised help. Those children seen by paediatricians and child psychiatrists were far more likely to be referred by other routes, and often the initial reason for referral was for a medical or behavioural problem.

A wide range of age and type of abuse was seen affecting boys and girls. Paediatricians only referred 11% of their cases to child psychiatrists.

Throughout our survey there was a trend towards seeing the problem as a 'police matter', rather than as a family disorder. All available evidence points to there being a far larger number of sexually abused children than is officially recognised. As professionals are becoming more willing to identify the problem, a co-ordinated strategy for dealing with these cases is needed.

Munchausen syndrome by proxy. R Meadow (Leeds).

Two families in which parents, by falsification, caused their children innumerable harmful hospital procedures were described in 1977. Since then I have encountered 2 further cases. Paediatricians have informed me of 8 other families. Details of the 15 children and their families have been studied to identify common features which may improve recognition and management.

The children have an unusually long and perplexing clinical syndrome requiring much investigation in hospitals. Despite active management symptoms persist or recur e.g. recurrent haematuria, hypernatraemia, anaemia, faecal or blood-stained vomiting.

The offender is the mother. Commonly she has:

1. Demanded (and enjoyed) coming into hospital with her child and appeared a happy addict of good living-in facilities for parents.

2. Worked in hospital or with children before marriage.
(3) A history of similar physical illness to that which she has projected on her child, her own symptoms having been rather cursorily investigated.

(4) A previous history of hysterical illness or fabrication by her of investigations and findings when she herself was ill.

(5) A particularly poor intellectual and emotional relationship with her husband.

Six of the families are from Yorkshire, but it is likely that the syndrome is widespread and often unrecognised. It is a dangerous condition with an appreciable mortality. Early experience suggests that positive management can prevent further problems.


The specialist adoption agency, Parents for Children, was set up two years ago to find families for children with special needs, i.e. older children, sibling groups, and handicapped. 37 children have been placed with adoptive families. There were 9 children in sibling groups, 10 Down's children, 2 severely subnormal multiply-handicapped children placed from long stay subnormality hospitals, 3 children with emotional/behaviour disturbance of such a degree that they were categorised as maladjusted; among the other children placed were some with conditions—such as cerebral palsy, Noonan's syndrome, adrenal hyperplasia, and achondroplasia. There were 5 disruptions of placement. The majority of the children referred to the agency had been in care for most of their lives, and many of them had had inadequate medical care, damagingly so in the case of 7 children. The majority of these children with special needs experienced particular problems after placement in their adoptive families and exhibited emotional symptoms for which their families required continuing social work support from the placing agency, and on occasion medical advice. It is particularly important that children with handicapping conditions are assessed before placement, that the adoptive parents are aware of these needs, and that after placement there will be the necessary services available, particularly if special schooling is required and specialist medical care.

In a number of couples who applied to the agency as adoptive parents, one or other partner suffered from a potentially serious condition. The importance of medical assessment and interpretation of such information is discussed.


It is thought important to offer emotional support to parents bereaved in the perinatal period. To evaluate this, a study has been planned in which bereaved parents are randomly allocated to a control (C) group, or a supported (S) group, and their emotional state assessed 6 and 12 months later.

Currently 14 C and 15 S families have entered the study and 4 C and 4 S were assessed at 6 months. A report will be presented of hospital routine in group C and extra support given in group S with preliminary results of the 6-month follow-up.

A tangible result of the study so far has been identification of complicated and emotionally-charged administrative procedures which affect parents shortly after bereavement. These include simultaneous registration of birth and death; collection and delivery of the certificate of burial or cremation; choosing the funeral arrangements, particularly given the uncertainties of hospital funerals; can the parents attend? how many babies in one grave? is a coffin used? is a funeral service held? can the grave be found afterwards?

Clarification of these points is important for all the staff in a maternity hospital and has enabled the child psychiatrist to give practical help to group S and thus be placed in a position to offer more general emotional support.

GUEST LECTURE. A guest lecture was delivered by Dr C Ounsted of the Park Hospital for Children, Oxford, on 'The development of temporal lobe epilepsy in childhood'.

Hypertrophic pyloric stenosis and the urinary tract. J D Atwell and P Levick (Southampton).

Observations have been made over the last 10 years of congenital anomalies of the urinary tract associated with hypertrophic pyloric stenosis. No previously recorded observations existed of urinary tract anomalies and hypertrophic pyloric stenosis. This investigation started as a result of operating on two infants with pyloric stenosis one of whom had bilateral megaloureter and the other pelviureteric junctional hydronephrosis, thus linking together a common smooth muscle disorder.

The patients studied can be subdivided into three main groups:

(1) Prospective study. 68 patients underwent pyloromyotomy during the 3-year period 1970–2. 64 of these patients had a limited IVP performed to determine the incidence of associated anomalies of the urinary tract; 13 of these were abnormal—an incidence of 19%.

(2) Retrospective study. 276 patients were operated
on for pyloric stenosis over the 10-year period 1960–9. The incidence of anomalies with a genetic basis was determined in this group and included inguinal hernia, undescended testes, hypospadias, and urinary tract anomalies.

(3) Other observations. This group included a follow-up of patients seen in the prospective study and other examples of the association of urinary tract anomalies with pyloric stenosis.

The findings suggest a genetic basis for the association of congenital anomalies of the urinary tract and pyloric stenosis.


The poorly mineralised neonatal skull allows good visualisation of intracranial structures by means of real-time ultrasound, and permits diagnosis of subependymal and intraventricular haemorrhage as well as structural abnormalities of the brain. In addition real-time ultrasound has been shown to be of value in following the course of hydrocephalus in neonates.

The three systems which produce a real-time image are linear array, phased array, and mechanical sector scanners. As a preliminary part of our investigation we examined the merits and disadvantages of each system. The linear array allows better visualisation over the tempo-parietal area of scalp, whereas the phased array and mechanical sector scanners permit good views through the fontanelle.

A study has been undertaken to correlate the appearance of the ultrasound scan with anatomical sections of neonatal brain. We have devised a method for systematic examination of the brain in a manner likely to give most information with least handling of the baby. Five ‘cuts’ of the brain are taken, three through the tempo-parietal area giving information on brain stem, pons, aqueduct of sylvius, third and lateral ventricles. Views through the fontanelle show the configuration of the ventricular system and offer clear images of the caudate nucleus, allowing diagnosis of germinal layer haemorrhage.

We conclude that the use of ultrasound is a reliable and safe method of examination of the neonatal brain. The information given by the scan correlates well with anatomical findings and allows accurate diagnosis of haemorrhage or hydrocephalus.


E-type prostaglandins (PGE) infused into the aorta or intravenously have become the initial line of emergency treatment in neonates whose pulmonary circulation depends on patency of the ductus arteriosus. We have evaluated the effectiveness of oral PGE₂ given for periods of 6 days to 5 months to 11 neonates with right ventricular outflow obstruction (RVVO) and 2 with interrupted aortic arch (IAA). Nine infants with RVVO were studied at intervals to determine the influence of oral PGE₂ on arterial oxygen saturation (Sao₂) or tension (Pao₂) and on plasma PGE₂ concentration.

Within 20 minutes of a dose of PGE₂, Sao₂ or Pao₂ rose by a mean of 41% of the pre-dose value (P 0·01) and plasma PGE₂ on concentration reached dose-related peak levels. The ductus arteriosus remained PGE₂-dependent for months. Infants with IAA improved, pulses becoming palpable and blood pressure rising to normal values within hours of starting treatment. Infants with RVVO all grew; four underwent repeat angiography which showed pulmonary arterial growth.

Oral administration of PGE₂ was at least as effective as intravenous and had practical advantages for both short- and long-term purposes. Medical palliation and elective surgery may be a better alternative to emergency surgery.


Son and daughter of nonconsanguineous parents showed an unusual combination of cellular immune deficiency, skeletal dysplasia, and progressive renal failure. Clinically, the patients had a peculiar phenotype with facial dysmorphism, dwarfism, and numerous pigmented nevi of the skin. Radiographic studies showed a spondyloepiphyseal dysplasia. Histologically, the cartilage cells were distended with lack of column formation. Studies of the immune system showed a numerical and functional T-cell deficiency, as shown by depressed E-rosette formation and negative skin tests to PPD, candidin, streptococcus antigen, and mumps. The girl died at age 6 years from renal failure. The clinical findings were those of a nephrotic syndrome, the histological findings those of an immune complex nephritis with mesangiproliferative histological changes. The pathogenesis is unknown. No abnormalities of the aminoacid, glycosaminoglycan, purine, or pyrimidine
Is overheating a factor in some cot deaths? A N Stanton, M A P S Downham, and D J Scott (Newcastle upon Tyne).

Clinical and pathological evidence of overheating was sought in a consecutive series of infants dying in Newcastle and Gateshead. Eight of 33 unexpected, unexplained deaths (cot deaths) were found to have histological changes in the small intestine of the kind described in association with heatstroke. Five of these had overwhelming clinical evidence of overheating, a sixth had major terminal symptoms, and the histories of the other two were unreliable. Small intestinal changes were not found in any of 12 deaths from chronic or congenital conditions and in only one of eight acute explained deaths—a baby who died with necrotising enterocolitis.

Seven of 34 cot death families interviewed had found their baby hotter than usual at death, and four other babies had a terminal pyrexia; 13 more babies had evidence of a terminal infection without observed fever. None had gastroenteritis. 15 of the cot death babies were excessively dressed or covered at the time of death.

The ability to generate heat increases rapidly with age in infancy, while sweating capacity remains relatively constant. Warming neonates excessively increases the incidence of apnoea. Overheating young animals experimentally or babies in incubators accidentally may cause sudden silent death.

The possibility that overheating contributes to some cot deaths has important implications for health education.


Despite reports that Crohn's disease is increasing in frequency in childhood in recent years, it still remains an uncommon disease in this age group. However, it is not uncommon for Crohn's disease to be considered as a possible diagnosis in children with a wide variety of symptoms and signs, and at an early stage it is still a difficult diagnosis to make particularly when recurrent abdominal pain is the main presenting symptom.

We have critically reviewed the early clinical features and initial investigations performed in 26 children with established Crohn's disease, diagnosed since 1975. We wish to emphasise the early symptoms and signs which were found to be particularly associated with Crohn's disease, and also the important role of well performed and appropriate radiology in making the diagnosis.

From our personal experience of these children and others referred with similar symptoms we propose a plan of investigation for suspected cases involving detailed questioning, followed by radiology and/or endoscopy as appropriate for the individual child. Such an approach minimises both the time and trauma to which the child is subjected.


Circumstantial evidence has previously been presented to the BPA suggesting that nutritional deficiencies, specifically minor deficiencies of folic acid, ascorbic acid, and possibly other vitamins, may contribute to the causation of neural tube defects. A prospective, multicentre trial of periconceptional vitamin supplementation in high-risk mothers provides further evidence compatible with this hypothesis.

<table>
<thead>
<tr>
<th>Mothers given periconceptional vitamin supplementation</th>
<th>Control mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant or fetus with neural tube defect</td>
<td>1</td>
</tr>
<tr>
<td>Infant without neural tube defect</td>
<td>140</td>
</tr>
<tr>
<td>Normal amniotic alpha fetoprotein</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>167</td>
</tr>
</tbody>
</table>

P (Fisher's exact test) <0.01.

National food policy and child growth. P C Elwood and O P Gray (Cardiff).

The Welfare Food Act 1940 gave entitlement to a milk supplement for pregnant mothers, infants under 5 years of age, and all schoolchildren. The provisions of this Act were substantially reduced in 1971 and further restrictions appear to be imminent.
In 1972 two randomised controlled trials were set up, both designed to mimic situations created by the 1940 Welfare Food Act.

One trial was initially based on a representative sample of 1200 pregnant women. Half of these were supplied with milk tokens entitling them to half a pint of milk free per day. There was no evidence of any effect of the entitlement on the pregnancy, judged by the birthweights of their infants. Their infants were then followed to age 5 years and half of them were supplied with milk tokens. Again there was no evidence consistent with benefit on the growth of the children.

The other trial was based on 581 schoolchildren aged 7 and 8 years. All were from families with at least 4 children, and of social class III manual, IV, or V. One-third of a pint of milk was supplied each school day for two years and this led to an increased growth of about 1.5 cm per year (P<0.05).

The relevance of these findings to our national food policy will be discussed.


The co-operative ALL study group BFM (Berlin/ Frankfurt/Munich) enrolled between October 1970 and March 1979 in sequence 355 children and adolescents being treated according to the Berlin ALL protocol. The study started in Berlin and after 4 years was extended to Frankfurt and Munich (study I, standard programme, 1970–6, n=141). Between October 1976 and March 1979 8 further paediatric departments within the Federal Republic of Germany participated in study II (standard programme, for ‘low risk’ patients, n=137, intensified standard programme for ‘high risk’ patients in two randomised modifications, n=77). In discriminating the two risk groups a risk index was used. The results up to 1 January 1980 are as follows:

Study I: 76/141 patients are virtually in complete continuous remission (CCR) with a median duration of 5 years. The therapy failure group (nonresponders, disease-unrelated deaths, relapses) comprises 65 patients (1/15/49). Out of 126 evaluable patients the ‘cure’ expectancy is calculated to be 58%.

Study II: 171/214 patients in CCR, median duration 17 months, failure group 43 patients (3/14/26). Out of 200 evaluable patients the calculated proportion in CCR (‘cure’ expectancy) is 78% for both the ‘low risk’ and the ‘high risk’ therapy group.

The results indicate that the Berlin ALL programme in its standard version has improved the outcome of childhood leukaemia by the impact of intensified and prolonged induction therapy. By the use of the same principle (intensification of the standard programme) the prognosis for patients with risk factors is equal to that of the ‘low risk’ groups, thus underlining the value of early intensification therapy in childhood leukaemia.

Underdiagnosis and undertreatment of asthma in children of primary school age. A N P Speight, E N Hey, and D A Lee (Newcastle upon Tyne).

All the 2700 7-year-old children in North Tyne-side were screened using a school-based questionnaire. Children with symptoms were seen for further study. Preliminary analysis of the results showed that approximately 13% of the children had wheezed since starting school. An attempt was made to assess the degree of disability suffered by these children and to review previous diagnosis and management.

Only 14% of the wheezy children had previously been labelled as asthmatic. All of these children labelled asthmatic had received some bronchodilator treatment. In contrast, of all the other wheezy children who had been given some other diagnostic label by their doctor (e.g. wheezy bronchitis, bronchitis, chest infection), only 11% had ever received bronchodilator treatment. Overall, two-thirds of the symptomatic children had never received bronchodilator treatment. The degree of disability suffered by these children appears to be considerable, as measured by time lost from school. One-quarter of the symptomatic children had lost more than half a year of schooling as a result of their asthma since starting school.

Children who had significant current symptoms were offered treatment for their asthma at a special clinic. Many appeared to benefit greatly though only longer follow-up will allow this to be assessed fully.


Children in Oxfordshire born after 1 July 1976 and not walking by 18 months are referred by health visitors for neurological and developmental assessment by a paediatrician at home, in an attempt to pick up undiagnosed cases of cerebral palsy at an early age. This survey, in conjunction with a prospective follow-up of certain categories of ‘at risk’ babies from the special care baby unit and a documentation of known cases of cerebral palsy, aims to determine as fully as possible the incidence and aetiology of cerebral palsy in this area. Of the first 160 late walkers assessed, 6 (3.8%) cases of
cerebral palsy and 4 (2.5%) cases of neurological abnormality were newly diagnosed. A further 16 children had previously diagnosed conditions (not cerebral palsy) likely to have delayed their development. Patterns of early locomotion, family history, social background, and developmental assessment scores on the remaining 134 'idiopathic' late walkers are discussed. The incidence of newly diagnosed cerebral palsy among late walkers born in 1977 for example makes a significant difference to the previously known overall incidence (2:1000) for that year in Oxfordshire. This survey helps to explain the difficulties in the accurate determination of the incidence of cerebral palsy.

**Home monitoring of blood glucose in diabetic children.** S Court and D Johnston (Nottingham).

Home monitoring was performed in 40 children age range 3–15 years, using Glucocheck devices. A composite blood glucose profile was constructed during one week for each of three consecutive months, a maximum of four samples being collected in one day. The child and family participated in interpreting the profile and adjusting the therapeutic regimen. Control was also assessed by 24-hour urine glucose and haemoglobin A1 measurement. Anxiety provoked by monitoring was assessed by standardised psychological questionnaires. 36 were able to complete monitoring, and none found the sampling unacceptable. Patient selection was biased towards those with unsatisfactory control.

In contrast to studies in adults, there was no marked variation in sequential profiles for individual children. In 12, previously unrecognised hypoglycaemia was identified, and in 8 this was recurrent and prolonged. Persistent marked hyperglycaemia was confirmed in others but could not always be corrected. Only three families provided inadequate data.

Of 21 children who have completed three months' monitoring, the change in diabetic control as judged by HbA1 and mean fasting blood glucose (MFBG) is shown.

<table>
<thead>
<tr>
<th></th>
<th>Improved</th>
<th>Unchanged</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1</td>
<td>8</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>MFBG</td>
<td>7</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

Home blood glucose monitoring is well tolerated but there are difficulties in interpretation. It is potentially useful in children with deteriorating control or where urine analysis is unreliable.

**POSTER PRESENTATIONS**

- Medical audit in neonatal care. D P Davies and T Williams.
- Suppressor cell activity in dermatomyositis. R F Eife.
- An auxological study of six patients with cerebral gigantism (Soto's syndrome). C C Forsyth, P J Smail, and J A Young.
- 2-D-echocardiographic diagnosis of the hypoplastic left heart syndrome. L Lange, H D Allen, S J Goldberg, and D J Sahn.
- Free drug level monitoring—two years' experience with carbamazepine and phenytoin. T A Moreland and G W Rylance.
- Propanolol and cold thermogenesis in the newborn baby. A I Mukhtar, K W Cross, and J K Stothers.
- Complementary breast-fed infants. A Nicoll, R Ginsberg, and J Tripp.
- Chemical and histological investigations following infusions of fat emulsions during parenteral feeding of neonates. F Pohlandt, H U Klor, W Mohr, and U Tollner.


An AHA confidential enquiry into child death. Y Sherman.

Phosphate treatment in X-linked hypophosphataemia. T E Stacey and D P Brenton.

Chronic active hepatitis in childhood: a review of 23 cases. A Veignente, V F Larcher, and A P Mowat.


GROUP SESSIONS

Child Psychiatry Section Workshop


British Paediatric Cardiology Section


The British Association for Paediatric Nephrology


British Paediatric Nutrition, Metabolism, and Pharmacology Group

Rickets due to an inborn error in the biosynthesis of vitamin D-hormone: deficiency of 25-OH-vitamin D3-x-hydroxylase. H K A Visser.
Isn't it time we took lead out of petrol? F W Alexander.
Dose dependent enzyme induction in anticonvulsant treated children. H Bartels.
The influence of dose and time of administration on transplacentally acquired pethidine in the newborn. T A Moreland.
Should we reduce the acid load of cows' milk based formulae for infant feeding? F Manz.

British Paediatric Tropical Child Health Group
Hospital admissions in children with sickle cell anaemia. Lily N Murtaza.
Plasma prolactin levels in undernourished lactating mothers. P Lunn.
A school-based approach as the second front in community health-care—the Kangazha experiment. M V Joseph.
The use of oral glucose electrolyte solution prepared with untreated well water in acute non-specific childhood diarrhoea. M Watkinson.
Hydrops fetalis in South Korea. Elizabeth Bryan.
Growth and social class in urban Nigerian children. Margaret D Janes.

Community Paediatric Group
The effects of personal health during pregnancy on fetal outcome
The strength and weaknesses of epidemiological approaches to the problem. Jean Golding.
What is the relationship between fetal nutrition, adverse birth factors, and subsequent development? J S Wigglesworth.
Drug and alcohol teratology. R W Smithells.
Why pregnant women don’t do what we tell them. Hilary Graham.

British Paediatric Immunology Group
Clinical manifestations of allergy in an infant population. D W Hide.
Successful marrow transplant for reticular dysgenesis. Karin Tiedemann.
Disturbance of functional activity of the alternative pathway of complement in sickle cell anaemia—more than one defect? V F Larcher.
Islet-cell antibodies in children with mumps infection. A Otten.
Is breast feeding enough to prevent atopic disease in susceptible children? D Stratton.
Immunological studies on allergic children and beekeepers. R Urbanek.
Polymorphonuclear leucocyte iodination response as an estimate of defective yeast opsonisation. D M Robertson.

British Paediatric Perinatal Group
Neurological development of the preterm infant. Penelope Palmer.
Isoimmune neonatal thrombocytopenic purpura. P Galea.
A controlled trial of intravenous aminophylline and face mask continuous positive airways pressure in apnoea of prematurity. Rosamund A K Jones.
The benefit of silver swaddlers. J K Stothers.
The role of neonatal intensive care in the prevention of death and handicap
The benefits of neonatal intensive care. M L Chiswick.
The hazards of neonatal intensive care. N R C Roberton.

British Paediatric Radiology Group
Bone scanning in childhood trauma. Helen Carty.
Skeletal maturation at the hand and wrist in normal children in Nottingham. P Small.
The 'air block' phenomenon in neonates. G M A Hendry.
Respiratory difficulty in infancy due to intrathoracic mass lesions. P S Thomas.
Echographic diagnosis of hydronephrosis pitfalls and difficulties. C Metreweli.
British Society of Paediatric Endocrinology

A study of the remission period in juvenile diabetes mellitus. O Hensey.
What are the medium term benefits of mono-component insulins? M Webster.

Assessment of diabetic control

(3) Filter-paper capillary blood glucose profiles in the assessment of diabetic control. A D Edelsten.
Melatonin and human puberty. M A Preece.
Variation in the patterns of female precocious puberty. D B Grant.
Growth pattern and gonadotrophin secretion in boys with delayed growth and adolescence. M O Savage.
Circulating levels of DHA in growth hormone-deficient children. M B Ranke.
Salivary cortisol levels during provocation tests in children. D A Price.
Thyroxine dosages in congenital hypothyroidism. J A Hulse.

British Paediatric Gastroenterology Group

Short stature as a primary manifestation of coeliac disease: a feature in need of emphasis. A Groll.
Loperamide inhibits cholera toxin induced secretion. Bhupinder Sandhu.
Adhesion characteristics of strains of E. coli isolated from children during an outbreak of acute diarrhoea: isolation of a colonisation factor II producing strain. D C A Candy.
Quantitative analysis of small intestinal mucosa in cows' milk protein intolerance. A D Phillips.
Pitfalls in the investigation of carbohydrate malabsorption in the neonate may be lessened by combined investigations. M J Harran.
Small intestinal absorption of neutral amino-acids and glycyl-1-phenylalanine in cystic fibrosis. P J Milla.

British Paediatric Oncology and Haematology Group

Guest lecture: The histiocytic disorders. M Nesbit (University of Minnesota).
Erythroid progenitor culture in the investigation of pure red cell aplasia. C Sieff.
The fall and rise of haemoglobin in the low birth weight infant. D Stevens.
Sickle cell anaemia in Birmingham children. Jillian Mann.
Acute splenic sequestration in SS disease in the last five years. Janet M Topley.
Pit counts and infections in childhood sickle cell anaemia. D W Rogers.
Effect of treatment on inhibitor levels in boys with haemophilia A and B with inhibitors. G H Hill.
Ewing's sarcoma treatment with high dosage radiation and adjuvant chemotherapy. Ann Goldman.
Nephroblastoma—25 years of cases with special reference to those under one year. Patricia H Morris Jones.
Comparison of cyclophosphamide and vincristine with cyclophosphamide, vincristine, and adriamycin in advanced neuroblastoma. J Ninane.

British Paediatric Respiratory Group

A survey of asthma in 7-year-old children in North Tyneside. D A Lee.
Ketotifen in childhood asthma. R C Groggins.
The effects of anti-mite measures on children with mite-sensitive asthma—a controlled trial. E R Verrier Jones.
Nebuliser medication: how much leaves the bottle? S A Ibrahim.
Respiratory patterns during sleep in bronchiolitis. F Silva.
Bronchial hypersecretion in preterm babies. C Wong.

British Paediatric Neurology Association
Multicystic encephalomalacia due to fetal viral encephalitis. S Lingham.
A family study of hydrocephalus due to aqueduct stenosis. Frances Howard.
Peripheral nerve conduction velocity and fetal nutrition. R O Robinson.
Multiple familial constriction rings with entrapment neuropathies. N Marlow.

Factors associated with periventricular haemorrhage in the very low birthweight infant. R W I Cooke.
Congenital myopathy in Lowe’s syndrome. F Hanefeld.
Fears of death in febrile convulsions are normal. J H Baumer.

Clinical aspects of neonatal neurology
What can be learned from neonatal behaviour? J A Macfarlane.

Richard Heyworth Dobbs
We record with regret the death of Dr Richard Dobbs on 21 August. Among his many distinguished contributions to paediatrics, he was Editor of the Archives from 1954 to 1969—the second longest serving editor of the journal—and President of the BPA 1970–71. He took a keen interest in the Archives after his retirement and was a frequent and friendly visitor to the editorial office.