mortality rate; I cannot. Can Dr Roberton quote any controlled study of present methods of neonatal intensive care to prove that expenditure in intensive care nursery reduces both mortality and handicap in babies of very low birthweight? In order to forestall another tirade from him I hasten to assure you that he cannot.

It is right that some paediatricians responsible for newborn care who work in certain regions of the country where perinatal mortality is high (not East Anglia or the South East) should press for increased expenditure on staff and equipment if these are inadequate. It is also right that some paediatricians similarly involved in newborn care should try to review the subject dispassionately and not have their judgement influenced by medico-political considerations.

Dickens, breath-holding, and The Hospital for Sick Children

Sir,

Douglas Gairdner, in his account of breath-holding attacks as described in Our mutual friend, asks if the hospital to which Johnny was admitted was The Hospital for Sick Children, Great Ormond Street.

Charles Dickens was keenly interested in that hospital from its foundation in the early 1850s, and was concerned that it only had about 30 beds 6 years after it had opened. On 9 February 1858 he said that 'even that small number, so forlornly, so miserably diminutive, compared with this vast London, cannot possibly be maintained unless the hospital be made better known...'.

Dickens presided at a dinner at the Freemasons' Hall to raise subscriptions for the hospital and his speech makes moving reading; there is a copy in the library at Great Ormond Street, and in the Complete works of Charles Dickens. He was appointed an Honorary Governor, and gave a public reading of A Christmas carol in aid of the hospital on 15 April 1858.

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Depression in mothers of young children

Sir,

Stephen Wolkind stated that nonclinicians are able to conduct standardised interviews. We use a microcomputer. We find that the computer is more consistent and reliable, and that it is also cheaper for it can be used for other tasks—such as data storage and statistical analysis. Furthermore there is evidence that patients answer computers more honestly than they answer doctors. Confidentiality is maintained because the information is inaccessible without knowledge of the computer program and possession of the data discs.

We have found that the Hamilton depression rating scale, widely used in psychiatry and considered a 'best buy', with the PET microcomputer, is simple to use and is well received by the subjects. This method was validated by the Institute of Psychiatry.

So far our studies indicate that 28% of mothers of asthmatic children are depressed. Clinicians failed to identify half these mothers, so we disagree with Dr Wolkind that an idea of 'whether a parent may be clinically depressed can generally be obtained in a few minutes' by the paediatrician. We are currently extending our studies to other paediatric clinics and to general practice.

The microcomputer produces an assessment in only 10 minutes and can be used immediately before the medical consultation. This avoids the problem indicated by Dr Wolkind of attempting 'a sudden switch... from asking about the child to conducting a mental state examination of the mother'. Thus the family: in need of extra attention can be identified and the time more profitably spent by the clinician in attempting to treat the problem.

References

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An improved sampling method to study the small intestinal microflora

Sir,

To obtain samples of juice from the upper small-intestine for microbiological study, a sampling tube is normally passed perorally or pernasally into the stomach, and is allowed to advance into the duodenum, either by normal peristalsis or by manual guidance under fluoroscopic control. Bacterial contamination of the outside of the tube and the lumen inevitably occurs when opened sampling tubes are used and some organisms isolated from the small-intestine may therefore be contaminants arising from more proximal areas of the gastrointestinal tract. We describe a simple method to prevent such intraluminal contamination.
Recurrent meningitis in a child with combined IgA deficiency and splenic hypoplasia

Sir,
Referring to the paper by Thong et al.¹ I describe a girl who presented in a similar way, also with compromised immunity.

A 12-year-old girl presented with two episodes of meningitis and one of septicaemia over a 2-month period, despite adequate treatment each time. Pneumococci were isolated on each occasion, and each time the serotype was different. Her medical history included referrals with localised cutaneous scleroderma (morphoea) and recurrent upper respiratory tract infections, but there was no history of recurrent infections in the family.

The following investigations were done: serum immunoglobulins IgG 9.45 g/l (normal 11.24 ± 2.35), IgM 0.7 g/l (normal 0.79 ± 0.33), IgA none detected. CH50 normal, C3 + C4 components of complement were slightly increased. Lymphocyte transformation by pokeweed mitogen and phytohaemagglutinin was sub-optimal. Escherichia coli antibodies (haemagglutination) were detected at a dilution 1 in 2 (patient serum), 1 in 64 (normal serum). Nitroblue tetrazolium screening test was normal. No Howell-Jolly bodies could be seen in the blood but an ultrasound scan failed to detect the spleen. An isotope scan showed the presence of a very small spleen in the left hypochondrium. The liver appeared normal.

The patient described by Thong et al.¹ was unusual in having only one detectable abnormality in the immune system. Other reports have suggested that children who have more than one immunodeficiency—for example, a defect in both the classical and alternate pathways of complement²—will be particularly vulnerable to recurrent meningitis or septicaemia.

In our patient it is tempting to speculate that the absence of IgA led to failure of immune exclusion with consequent severe bacteraemia. Clearance of circulating bacteria by macrophages in the hypoplastic spleen was likely to have been impaired. Activity of the alternate pathway of complement was probably reduced as occurs in the functional hyposplenism of sickle cell disease³ or after splenectomy⁴ where fulminant pneumococcal infection is also seen.

In cases of recurrent meningitis where a cerebrospinal fluid fistula cannot be demonstrated full immune investigation is required. Evidence of splenic hypoplasia should be sought in each case. With the use of ultrasound a normally sized and positioned spleen can be demonstrated in a non-invasive way, and confirmation obtained by isotope scan in cases where no convincing echoes are seen. It is stressed that the absence of Howell-Jolly bodies from the blood cannot be relied on to exclude a diagnosis of splenic hypoplasia.

I thank the Department of Immunology, East Birmingham Hospital, for help with this case.

References

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Intractable diarrhoea of infancy and latent otomastoiditis

Sir,
The article by Salazar de Sousa et al.¹ prompts us to report our recent experience.

In 1980 13 infants under age 6 months were in hospital with prolonged and resistant diarrhoea of unknown origin. Each had already received some kind of antimicrobial