Correspondence

Results of selective treatment of spina bifida cystica

Sir,
I congratulate Lorber and Salfield on their paper1 and support its underlying humane philosophy and emphasis on full counselling with the infant's parents. The paper is very timely in the present climate of debate. However, I was disappointed in their policy of dissuading parents from taking home their infants for whom active management was assessed as inappropriate, and in the unconvincing reason given—that they would then receive inappropriate treatment, including antibiotics, presumably from their GP. If, as I believe would be the case, the GP is involved during the initial assessment of the infant and the counselling of its parents then he should also be involved with the plans for subsequent management. Paediatricians are becoming more aware that many infants and children with incurable diseases, or who are dying, can be nursed lovingly and adequately at home. This is possible when parents are fully counselled in the management of existing and anticipated problems before the babies are discharged, and have well informed support from both the GP and his team and the hospital team. Indeed it is likely that the family will cope and find the experience rewarding and even therapeutic in assisting them to come to terms with their grief and bereavement. I have experienced the satisfaction that a paediatrician also can receive by being actively involved in the home care of an infant with severe spina bifida cystica until its death, and found the parents' expression of gratitude that their infant died at home with the family extremely moving. In short, we must not underestimate the parents.

Reference

L G EVANS-JONES
Chester City Hospital,
Hoole Lane,
Chester CH2 3EH

Professor Lorber and Dr Salfield comment:
Parents were given the choice of looking after their child at home, or having the child cared for in our hospital or in the referring hospital. Very few looked after their baby at home but those who did usually found this a rewarding experience. However, this was not a policy which we encouraged for most families. Many of our patients were referred from far away and it would not have been feasible to maintain the necessary close contact with the general practitioner or repeatedly to discuss the very difficult questions concerned.

Because of these difficulties, we have known patients looked after at home or in other hospitals who received 'intensive' treatment which produced unnecessary and prolonged suffering. We have also seen patients, not initially referred to us, who were sent home without adequate palliative therapy and whose parents complained of the suffering their child experienced, even though the parents and doctors accepted the principle of no active treatment.

It has been our experience that most parents preferred their child to be looked after in hospital and were grateful for the loving nursing care the child received. We feel that active palliative care is usually best provided in a unit in which the medical and nursing staff are fully experienced and conversant with the problems of looking after infants with spina bifida.

Water supplementation in jaundiced babies

Sir,
The futile practice of giving jaundiced babies extra drinks of plain water or 5% dextrose is firmly ingrained in nursery lore, as indeed is the giving of water to newborn infants for all manner of mistaken reasons. I was glad to see that Mathew and Wharton, describing their investigation and management of neonatal jaundice,2 may review their practice of giving extra water. It is not surprising that the study they cited led failed to show any worthwhile difference in serum bilirubin levels or weight loss between babies who received water supplements and those who did not.

The measured concentration of bilirubin in plasma must rise in dehydration although the total bilirubin level remains the same. However, it is a fallacy to believe that water alone can correct dehydration. Water is rapidly excreted, does not satisfy thirst or hunger except momentarily, and serves no useful purpose. Most neonates are effectively managed on low sodium diets.3 For the fluid loss to be made good it is necessary to provide more sodium. The simplest way to do this is to give more milk, preferably using one of the less drastically sodium-reduced formulae. Alternatively, a commercial dextrose-electrolyte mixture such as Dextrolyte (Cow and Gate) (3.5 mmol per 100 ml), or a sodium bicarbonate supplement of 2 mmol/kg a day can be used. Rehydration is desirable so that inappropriate action is not taken on the basis of a spuriously raised bilirubin concentration, but using ordinary water for the purpose is unphysiological and misleading.

References
Device for continuous urine collection in the newborn

Sir,

I read the detailed description given by Lund et al.1 with great interest. Two years ago, while studying very preterm babies, I began to use an almost identical system. Since then I have made several modifications which have increased its versatility, simplified the changing of the slings, and greatly improved its acceptability for use with very small and immature subjects (Figure).

As our nursery is equipped with three different kinds of incubator it is inconvenient to use apparatus which matches the fittings of only one particular model. I therefore designed a Perspex tray, 62 × 33 cm, which can replace the mattress in the base of any incubator. A double slope was made to keep the apparatus shallow (height 7-5 cm) so that the baby remained in the normal nursing position within the incubator, and at the same time provided a sufficiently steep angle in the base of the tray for efficient urine drainage. Each end of the apparatus base consisted of a shallow Perspex 'valley' which sloped from either side at an angle of 15°; the central V was 3-5 cm below the top of the tray at either end and sloped lengthways towards the centre of the apparatus at 5°, reaching a drainage tube where the ends met. This arrangement gave excellent urine drainage despite the fairly shallow lengthways slope, as the urine tended to form a small rivulet in the central groove. In any case the flow could still be increased by using the incubator base tipping mechanisms which were not obstructed.

The most convenient arrangement was to lead the drainage tube out of the incubator through one of the low hood ports and then collect the urine into disposable plastic plasma transfer packs. Being expandable these bags required no venting, and being outside the incubator hood, modifications—such as collecting into a dry ice container—were easier and safer to make.

In response to comments from nurses about the awkwardness of fixing the sling with stainless steel rods we used velcro and this made sling-changing a quicker and easier procedure. Two 2 cm strips of the 'hooked' side of velcro were stuck either side of the tray and 3 strips at either end, and each cloth sling had the 'fur' side sewn along each edge.

The last modification was to substitute a softer, finer material for the 30 × 20 threads/inch nylon mesh which was used initially; although the nylon was satisfactory for the larger more mature babies it was too abrasive against the skin of smaller ones, particularly those below 1250 g. We now use georgette, a much softer, finer material with 100 threads/inch which we find allows the rapid passage of urine without absorbing any and which retains all but the most fluid of stools. Because of its very fine composition the edges of the sling which are stretched over the sides of the Perspex need to be reinforced with cotton or similar material. Even this material has produced a slight soreness over the knees and malleoli on babies of about 1 kg after 2 or 3 days' use.

Reference


Henoch-Schönlein purpura after yersiniosis

Sir,

Henoch-Schönlein purpura has been associated with many infective agents, but I have been unable to find any reports connecting it with Yersinia enterocolitica infection.

A 5½ year-old girl was admitted with a 1-week history of abdominal pain and a 2-day history of tender ankle joints and purpuric rash on the legs. On admission typical Henoch-Schönlein maculopapular purpuric rash was noted on the buttocks and on the extensor surface of the legs. The ankle joints were tender and swollen. She complained of abdominal pain, and there was blood in the stool. Blood pressure and temperature were normal. Antibody titre against Y. enterocolitica serotype 3 was 200 at admission and 50 ten days later. Stool culture was negative. IgA was moderately raised and there was slight proteinuria. Platelet count, bleeding time, prothrombin, C₉ complement, and barium enema were normal.

In the first week after admission she continued to have severe abdominal pain and was given prednisone 20 mg