bridge if a prospective assessment of joint movement has not been performed in paralysed infants.

We agree with the Cambridge experience that 'fighting the ventilator' is likely to predispose towards pneumothorax. We do not recommend withholding pancuronium for fear of joint contractures but merely wish to report that joint contractures may occur in association with its use, and attention to regular limb physiotherapy may prevent this occurrence. In addition, we would support the suggestion that other methods of inhibiting unwanted respiratory activity in ventilated infants should be investigated further before assuming that pancuronium is the drug of choice in this context.6

References


S K Sinha and M I Levene
University of Leicester School of Medicine,
Leicester Royal Infirmary,
Leicester LE2 7LX

Correspondence 801

Monitoring of intracranial pressure

Sir,

In their short report, Levene and Evans1 suggest a 'new' method for continuous measurement of intracranial pressure. We would question, unless a theoretical or clinical reason is given, their statement that 'subarachnoid catheters may be better suited to long term monitoring', especially since these catheters are usually kept in place for short periods (76 hours was the longest duration in their study). Furthermore, insertion of an extremely large needle (16 G) into the fontanelle of a neonate seems unnecessarily invasive and might greatly increase the risks of trauma to brain tissue and infection. In 1982 we described a method of intracranial pressure monitoring using a much smaller (22 G) catheter.2 This method has been proved to be highly reliable and safe.

Intracranial hypertension, per se is of little clinical importance. Maintenance of cerebral perfusion pressure, adequate to ensure a cerebral blood flow and therefore sufficient substrate supply for cerebral metabolism, may be an important factor in the mortality and morbidity of childhood central nervous system diseases.3 We have previously shown4 that in cerebral ischaemia, the late development of increased intracranial pressure and its treatment does not significantly affect outcome in these patients. It is the severity of the ischaemic insult that

Dr Singh and Levene comment:

We thank Dr Singh for his letter. Unfortunately he is mistaken in his belief that paralysed infants lie in an extended posture. They adopt the classical 'frog position' seen in severely hypotonic infants. Their arms are semi-flexed, wrists pronated, hips abducted, and knees partially flexed—certainly not fully extended. The knee contractures we noted fitted closely the position of partial knee flexion seen in paralysed infants. We feel that Dr Singh's other points have already been discussed by us.

Monitoring of intracranial pressure

Sir,

In their short report, Levene and Evans1 suggest a 'new' method for continuous measurement of intracranial pressure. We would question, unless a theoretical or clinical reason is given, their statement that 'subarachnoid catheters may be better suited to long term monitoring', especially since these catheters are usually kept in place for short periods (76 hours was the longest duration in their study). Furthermore, insertion of an extremely large needle (16 G) into the fontanelle of a neonate seems unnecessarily invasive and might greatly increase the risks of trauma to brain tissue and infection. In 1982 we described a method of intracranial pressure monitoring using a much smaller (22 G) catheter.2 This method has been proved to be highly reliable and safe.

Intracranial hypertension, per se is of little clinical importance. Maintenance of cerebral perfusion pressure, adequate to ensure a cerebral blood flow and therefore sufficient substrate supply for cerebral metabolism, may be an important factor in the mortality and morbidity of childhood central nervous system diseases.3 We have previously shown4 that in cerebral ischaemia, the late development of increased intracranial pressure and its treatment does not significantly affect outcome in these patients. It is the severity of the ischaemic insult that