

doxapram was given in addition to aminophylline and the blood theophylline concentrations of both babies were in the region of 11 to 13 mg/l.

Although Sagi *et al* described no complications attributable to doxapram in any of their five patients, we were nevertheless not surprised by our experience as the data sheet for doxapram warns of agitation and increased skeletal muscle activity, especially when it is used concurrently with aminophylline. It is possible that our two babies were for some reason unusually susceptible to the observed reaction but their state of agitation was so alarming that we would hesitate before using these drugs in combination again, despite the beneficial effect on the frequency of apnoea. There is little information available on the efficacy of doxapram alone in the treatment of neonatal apnoea and further clinical trials are indicated.

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Dr Sagi and co-workers comment:

We were glad to hear that our report¹ had stimulated others to try doxapram when apnoeic attacks persist despite adequate concentrations of blood theophylline.

The signs of central nervous system overstimulation observed in two preterm infants treated by Drs Dear and Wheeler were not observed in any of over 20 patients we have treated with doxapram and aminophylline combined. Moreover, in our report we mentioned one infant who had inadvertently received 5 mg/kg over two hours without adverse effects.

Doxapram alone has already been found effective in the treatment of apnoea of prematurity.² We have recently completed a double blind trial on 16 preterm infants with idiopathic apnoea, comparing doxapram and aminophylline. While neither drug had a significant advantage over the other, doxapram alone was found beneficial.

References

- Sagi E, Eyal F, Alpan G, Patz D, Arad I. Idiopathic apnoea of prematurity treated with doxapram and aminophylline. *Arch Dis Child* 1984;59:281-3.
- Burnard ED, Moore RG, Nichol H. A trial of doxapram in the recurrent apnea of prematurity. In: Stern U, Oh W, Friis-Hanson B, eds. *Intensive care in the newborn, II*. St Paul, Minnesota: Mason Publishing, 1978:143-8.

Malabsorption of vitamin B₁₂

Sir,

We were interested to read a case report by Conway *et al* on vitamin B₁₂ neuropathy in a 6 year old.¹ The failure to thrive in their patient before treatment with vitamin B₁₂ is similar to two siblings that we reported² with the Imerslund-Grasbeck syndrome. We too were able to document a rapid increase in weight after treatment with parenteral vitamin B₁₂. It would seem, therefore, that selective malabsorption of vitamin B₁₂ should be added to the list of rare causes of failure to thrive in children.

References

- Conway SP, Gillies DRN, Littlewood JM. Vitamin B₁₂ neuropathy in a 6 year old. *Arch Dis Child* 1984;59:575-6.
- Campbell AN, Inglis J, Paynter AS. Failure to thrive associated with the Imerslund-Grasbeck syndrome. *Postgrad Med J* 1981;57:509-10.

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BPA response to 'Healthier children thinking prevention'

Sir,

I sympathise with the views expressed by another senior clinical medical officer.¹ In my experience, district medical officers and specialists in community medicine do not have any paediatric postgraduate qualifications such as the Diploma of Child Health, as mentioned by my colleague. Paediatric services should be run by accredited paediatricians whether the children in their care happen to be seen in hospitals, schools, nurseries, or at home.

Reference

- Anonymous. (A senior clinical medical officer). BPA response to 'Healthier children thinking prevention' (letter). *Arch Dis Child* 1984;59:594-5.

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Ultrasound diagnosis of gastro-oesophageal reflux

Sir,

Naik and Moore suggest that ultrasound should replace the conventional barium meal examination for suspected gastro-oesophageal reflux.¹ In addition to exposure to radiation the barium oesophagram is not 'physiologic' since barium is not a normal meal, and is said to have a 15% false negative rate which, theoretically, could be avoided if one were able to use longer periods of observation. There is a more important diagnostic limitation of the barium oesophagram, however, which does not seem to have been circumvented by ultrasound. Gastro-oesophageal reflux is very common, especially in infants, and is self-limiting and benign in the overwhelming majority.² Any diagnostic method relying on the simple finding of retrograde flow of gastric contents into the oesophagus such as the barium oesophagram has to prove a high specificity, that is, the ability to identify *clinically important* reflux without too many false positive results.^{3,4} Indeed, recent studies show an inordinately high false positive rate for the barium oesophagram in comparison