efficiency have precise scientific meanings and should be used correctly.

References

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Drs Kohler and Pritchard comment:
Mathers and Milner are correct to point out that the term diagnostic accuracy has been used loosely in this paper.\textsuperscript{1} We found that it became very confusing to try to present false positive and false negative data for each type of tumour for each preoperative diagnostic method; Table 2 in our paper evolved as a comprehensible compromise.

We have, however, calculated the diagnostic efficiency of ultrasound for neuroblastoma to be 87-4\% (and for Wilms' tumour to be 89-3\% as shown above). The diagnostic efficiency for intravenous urography for neuroblastoma and Wilms' tumour was 86-2\% and 89-4\% respectively. This confirms our statement that ultrasound was no more efficient than intravenous urography in the diagnosis of these two tumours.

We used the term diagnostic sensitivity only once when quoting directly from a paper which specifically used this term.

Intensive care and neonatal mortality

Sir,

Professor Yu and co-workers comment:
Dr Reynolds has pointed out, quite rightly, that it is important to quantitate the intensity and duration of neonatal intensive care that very low birthweight infants receive during their initial hospital admission, and to correlate these factors with their survival and quality of survival.

In the same four year cohort of very low birthweight infants described in the late mortality study,\textsuperscript{1} 66\% required assisted ventilation for a median of five days (range 1-80 days) and 55\% required parenteral nutrition for a median of nine days (range 1-60 days).\textsuperscript{2} We have also correlated a range of perinatal events experienced by very low birthweight infants including early morbidity factors and details of therapeutic intervention, with hospital survival\textsuperscript{3} and quality of survival.\textsuperscript{4}

Other markers of the 'extent of intensive care required' referred to by Dr Reynolds are the durations of intensive care and total time spent in hospital. The mean length of stay in the respirator section of the neonatal intensive care unit for the four year very low birthweight cohort was 30 days, in hospital survivors.\textsuperscript{5} Their mean length of total hospital stay was 70 days (gestation at discharge was mean (SD) 40-2 weeks, (4-2)).\textsuperscript{6} Thirty five per cent of the survivors in this four year cohort were discharged after 40 weeks gestation. The infant mortality after discharge (5-8\%) was significantly higher than that in infants who were discharged before 40 weeks gestation (1-1\%). Major disability defined as cerebral palsy, developmental delay (menthal developmental index on the Bayley sales more than 2 SD below the mean), blindness, sensorineural deafness, epilepsy, and hydrocephalus were significantly more common in survivors with prolonged hospital stay compared with the remaining survivors (27\% v 15\%).

References