Table South West Thames: No (%) of babies of birthweight <1000 g resuscitated and surviving to go home

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<tr>
<td>Resuscitated:</td>
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<tr>
<td>St George’s Hospital</td>
<td>13</td>
<td>18</td>
<td>18</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>Rest of SW</td>
<td>40</td>
<td>39</td>
<td>42</td>
<td>37</td>
<td>44</td>
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<tr>
<td>Total</td>
<td>53</td>
<td>57</td>
<td>60</td>
<td>64</td>
<td>72</td>
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<td>Surviving to go home:</td>
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<tr>
<td>St George’s Hospital</td>
<td>4 (31)</td>
<td>10 (56)</td>
<td>9 (50)</td>
<td>16 (59)</td>
<td>18 (64)</td>
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<tr>
<td>Rest of SW</td>
<td>4 (10)</td>
<td>10 (26)</td>
<td>17 (40)</td>
<td>11 (30)</td>
<td>21 (48)</td>
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<td>Thames Region</td>
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<tr>
<td>Total</td>
<td>8 (15)</td>
<td>20 (35)</td>
<td>26 (43)</td>
<td>27 (42)</td>
<td>39 (54)</td>
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being effectively resuscitated and generally around the region are being managed so that they can go home. The greater expectations have implications for the provision of care. Intelligent anticipation by regional obstetricians with in utero referral is now commonplace, and baby units that are not staffed to practise even short term care provide effective resuscitation, so that the percentage of infants dying before transfer to an intensive care unit has fallen from 40% in 1980 to 19% in 1984.

References


NEIL MCINTOSH
St George’s Hospital Medical School, London SW17 0RE

Food related asthma: a difference between two ethnic groups

Sir,

I read the article by N M Wilson with interest. I was not surprised by the findings and feel I must express some reservation regarding its conclusions.

As a severely atopic child growing up in South India I can remember well my parents’ admonitions relating to iced and fizzy drinks, fried foods, nuts, and chocolate. A deep sense of guilt, and a heavy wheeze, often accompanied my return home from children’s parties. In the family it was thought that usually caused the atmosphere of dark suspicion and recrimination did little to alleviate bronchoconstriction. A school mate suffering from recurrent cystitis had similar food restrictions imposed (ice ‘brought a chill to the kidneys’).

Auto suggestion certainly played a major role in my reaction to foods. When, at the age of 21, I made the decision to remove milk and eggs from my diet a complete and permanent resolution of eczema resulted within weeks. Asthma that had been controlled for eight years only by the use of continuous systemic steroids regressed to four or five attacks a year. These are now triggered off by common antigen exposure—that is, house dust, pollens, and heavy exercise.

There are widespread food taboos on the subcontinent. The above mentioned foods are often incriminated in many relapsing ailments—for example, diarrhoea and migraine. Conversely, foods considered beneficial, like milk and eggs, are rarely, if ever, considered for indictment.

I therefore find it difficult to accept the conclusion that Asian asthmatic children have food sensitivities that are in any way excessive or peculiar. A control study of Asian children with non-asthmatic chronic disorders might be of value. It would also be interesting to know what proportion of the children studied derived from homes where first or second generation traditional influences still apply.

CAMILLE DE SAN LAZARO
Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP

Dr Wilson comments:

The implication of Dr de San Lazaro’s letter is that the ethnic difference found in the survey could merely be the spurious result of cultural taboo and that any experience of food related asthma in the children was due to suggestion. She provides no evidence, however, that her symptoms as a child, after ingestion of certain incriminated foods, were in fact psychogenically determined rather than a genuine response to the ingested substances. In contrast, the claim that ice, fizzy drinks, and fried foods can precipitate asthma in Asian subjects was based on the results of controlled challenge tests. It is highly unlikely that these positive responses were due to suggestion even when the tests were performed single blind. For example, ice but not placebo induced a significant increase in bronchial responsiveness that was greater at 90 than 30 minutes after ingestion, without a change in resting lung function. Because of the way the tests were conducted the subjects were unaware whether a positive response had occurred or not. Suggestion can undoubtedly induce bronchoconstriction, but an increase in bronchial responsiveness due to psychogenic factors has not been reported. Admittedly, one cannot be sure that every child giving a positive answer in the survey had experienced such an effect nor that all those with negative answers had not. However, positive histories were confirmed in almost all of the Asian children challenged with ice, cola drinks, and fried foods. On the other hand, asthma in the older child due to milk or egg intolerance, in the experience of myself and others using diagnostic elimination diets, is uncommon. It is not suggested that the incriminated substances are the cause of asthma in Asian children but rather that they act as an asthmogenic stimulus, as do exercise and smoke in asthmatics in general.

A control study of Asian children with non-asthmatic chronic disorders might be interesting but irrelevant. The fact that other disorders such as cystitis may be erroneously
attributed to the same substances does not invalidate the asthmatic response that has been shown.

All the children were born in this country, but cultural influences may still prevail. I maintain that this particular folklore is based on fact.

References
1 Wilson NM. Food related asthma. A difference between two ethnic groups. *Arch Dis Child* 1985;60:861-5.

Problems facing women who seek a career in paediatrics

Sir,

As the pair of successfully matched job sharing doctors mentioned in Dr C Rees's annotation we have encountered many of the difficulties she lists. We would still like to emphasise, however, the hopeful side of the future for women in paediatrics.

In September 1984 the proportion of female consultants in post was 17%; between 1978 and 1983, 20% of new consultants and senior registrars were women. Around 1968, when these new consultants finished medical school, the proportion of women graduating was 24%. Women are, therefore, relatively well represented in paediatrics. We are certainly more fortunate than those in other acute specialties: for the same period, only 4% of new consultants and 7% of new senior registrars in general medicine were women.

As the proportion of female graduates entering paediatrics increases the requirements for part time work will rise. There are also men who would appreciate a period of part time work, either for writing up research or seeing more of their young families. Is it not time that the British Paediatric Association set up its own job share register?

References

V VAN SOMEREN AND L REES
Guy's and St Thomas's Hospitals,
London SE1 9RT

Dr Chambers, secretary of the British Paediatric Association, comments:

This is now being done: enquiries to Dr Rosamond Jones, 15 Fairfield Lane, Farnham Royal, Bucks.

Risk and pertussis vaccine

Sir,

During the current epidemic of whooping cough many parents are reconsidering pertussis immunisation for their infants, and paediatricians are being asked about risks and benefits. The National Childhood Encephalopathy Study (NCES) conducted with the close cooperation of paediatricians in 1976-79 was designed to help answer their questions, and we are often asked about the interpretation of our results.

The NCES was a case control study in children admitted to hospital with acute neurological problems, in which we compared the histories of immunisation shortly before onset in cases with similar histories in controls. The first report included only 1000 of 1182 children notified to the study, though inclusion of the remaining children did not materially alter our findings. Our analysis included all children without regard to any alternative explanation apart from pertussis immunisation. This epidemiologically essential approach is not always understood and has led some to believe that the study shows the risks of pertussis vaccine to be greater than they are. It has also been suggested that our estimate of risk is too low due to bias in case reporting, but, as explained in our report, this is unlikely to have materially affected the results.

We reported two types of risk estimate:

(a) Relative risk. There was a small but significant excess risk of children having had DTP vaccine in the seven days before onset of a serious neurological disorder. Most of this excess was in the first 72 hours. Fortunately, most recovered quickly and were apparently normal when followed up at least a year later. No recognisable 'post pertussis immunisation syndrome' was found.

(b) Attributable risk. The attributable risk of these events was about one in 140 000, but the central estimate of risk of death or permanent damage comes to around one in a third of a million doses of DTP vaccine in children who were assumed (but not proved) to have been previously fit neurologically. We stress that this figure must be interpreted with caution because the 95% confidence limits are very wide and it assumes all relevant cases were notified. In fact it is based on only seven children found in a three year period. Of these seven, two died, one with Reye's syndrome and one with an overwhelming viral infection. One child with major defects had Coxsackie B5 virus isolated from the CSF, which could have been the cause of illness. This leaves four children, only one of whom was severely handicapped when last seen, with no alternative explanation for their illness. The real cause of the handicap in these children remains in question—was it a reaction to vaccine or did they have some other undiagnosed problem? It must be remembered that pertussis immunisation is given at the very age when children are most likely to manifest serious neurological disorders. In the circumstances it is clearly unwise to attribute a causal connection in individual cases. Our view remains, therefore, that the risk of death or brain damage attributable to pertussis vaccine, if it occurs...