during ventilator inflation, lead to the development of a pneumothorax. In fact, both are beneficial, the former improving blood gases[5] and the latter resulting in increased compliance.[6] The 'active expiratory reflex' rather describes the interaction when ventilator inflation occurs only within a respiratory window at end inspiration.[7] This combination does of course generate the largest transpulmonary pressure swings and hence by alveolar overdistension could cause rupture. Whether the succeeding expiratory effort is, however, active or passive remains controversial, the magnitude of oesophageal pressure swing may be inaccurate in infants with respiratory distress syndrome,[8] and only electromyogram recordings will conclusively answer this but until recently have technically not been feasible. Our research is not directed at trying to prevent passive expiration but rather at reducing the incidence of pneumothoraces among other complications, and it seems likely that if ventilator inflation could be directed outside the 'respiratory window' we have described[7] this may be possible. Fast rates are not always successful;[9] the answer seems more complex than simply reducing the inspiratory expiratory ratio or increasing the rate—hence we emphasise the necessity for further investigation of spontaneous respiratory activity during ventilator inflation and a greater understanding of the interaction of the two.

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## Choice of feeding preparations for the newborn

Sir,

As a paediatric dietitian I read with interest Dr Bamford's comments on the choice of feeding preparations for the newborn.[1] The choice of a modified baby milk is, as he points out, virtually an impossible choice as all comply with the guidelines of the Department of Health and Social Security.

In my view the solution is for a shared contract. An agreement could be made with the baby food manufacturers to supply their appropriate baby milk formulas at an acceptable set price to maternity units, children's hospitals, and paediatric units. (Such a contract has been accepted unofficially in the past and is likely to be formally accepted if supported by paediatricians.) This would do away with 'doubtful incentives' and might encourage the baby food manufacturers, who no longer have to compete for business, to donate a portion of their shared profits to paediatric research!

If breast feeding, for whatever reason, is not undertaken then the choice of baby milk, from the low solute range, should be made by the mother, particularly if she is distressed at being unable to breast feed. There is a clear variation in cost, which is of major importance for many families. If determined mothers are forced to feed their infants on a product they may, on discharge from hospital, change the formula, which could unsettle the infant.

We must be open minded and supply a choice of formulas that meet the requirements of young infants. More importantly, we must show we are unbiased. Supplying only one brand of baby milk formula is misleading as it implies to the general public that a particular health authority considers this product to be the best infant formula available. That the decision has been made only for financial reasons is not obvious and it allows the selected food manufacturer to use the contract award for sales promotion.

The undesirability of relying on one baby milk formula was emphasised recently when one powder was condemned as a suspected source of salmonella and immediately withdrawn. Had the ready to feed milk been affected, units solely using the brand in question would not have been able to offer an alternative. The fact that the incident happened in the Christmas period intensified the problem.

Expert opinion on the finer differences in baby milk formulas is available from paediatric dietitians, who are always pleased to advise.


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Sir,

The seductive blandishments of the milk food industry described by Dr Bamford[1] have been avoided in at least one hospital for six years. Here, midwives and doctors recite 'all baby milks approved by the Department of Health and Social Security are suitable. If you have a particular milk which you wish to use, we will try to provide it during your baby's stay in hospital.' A recent and unexpected bonus was the absence of organisational problems when Osterfeed was suddenly withdrawn.

Product endorsement by hospitals is actively sought by infant food manufacturers, and perhaps to a greater degree than many paediatricians are aware. The ready to feed