isolated finding on a neurodevelopmental examination provide information that is useful to a teacher in planning a teaching programme? It is well known that there is a wide range of normal maturation in this age group—a finding at one examination may be no longer present a few months later. And what of a danger of labelling a child, so that a 5 year old who may be otherwise doing perfectly well is labelled as having a problem?

Finally, there are absolutely no data to suggest that an examination of this type makes any difference to outcome. It would have to be shown that children who underwent such an examination at school entry would have an outcome that was better than children not so examined. Such a study would be extremely difficult to undertake because of the multitude of other variables that effect functioning.[2]

Given unlimited resources, one could perhaps support these examinations because they may provide reassurance to parents and teachers. In most communities such a situation does not exist, and arguments could be made against them from a cost effectiveness point of view. It seems more appropriate that nurses continue to be involved with children at school entry, but only to perform vision and hearing screening and to review health and developmental problems, perhaps with the aid of detailed health questionnaires completed by parents and consultation with teachers. During the first year or two at school, teachers will certainly identify a further group of children who give rise to concern. The doctor would thus be available in a consultative capacity to assess those children identified by the nurse or teacher, or both, as having problems.

While many would support the continued routine school entry examinations, there is precious little evidence that it is either a cost effective or valid method for reducing school problems. In the face of diminishing resources it is essential to provide harder data to justify their existence.

References

[1] Whitmore K, Bax M. The school entry medical examination. *Arch Dis Child* 1986;**61**:807–17.

[2] Oberklaid F. The ritual school health examination. An idea whose time has passed? *Aust Paediatr J* 1985;**21**:155–7.

FRANK OBERKLAID
Royal Children's Hospital,
Melbourne,
Victoria,
Australia

Drs Bax and Whitmore comment:

Dr Oberklaid's letter invites us to write another article! The purpose of our own article was to describe our present clinical method of conducting a school entrant medical examination and not to justify the procedure. We have referred to this in passing in other articles (including one by us to appear in *Dev Med Child Neurol* soon).[1 2]

Briefly, to take up some of Dr Oberklaid's points:

(1) We have good evidence that our routine examinations detected health problems that were not known about in the preschool health service: 94% of children whom we discovered had problems had not seen their general practitioner for those problems within the last 12 months and a third of the children we examined had no available preschool health notes; of those for whom notes were available, two out of five had not been seen since the age of 2.

(2) We do not see why the school health service should aim to employ doctors who are less competent than our aged selves.

(3) In the past teachers have often received dribs and drabs of information from doctors outside school, which are confusing to them. It is indeed our practice to discuss in detail our findings with the teacher and to discuss and explain to them the importance of findings. Our examination aims to report on the present developmental state of the child and we are extremely cautious in talking to teachers about drawing any implications for the future. Nevertheless, our neurodevelopmental examination has proved extremely robust in making predictions, as our own data suggests (see our article to be published in *Dev Med Child Neurol*) and that of other workers who have used our scheme.[3]

(4) It is quite true that we are bad at treating many forms of neurodevelopmental disorder from cerebral palsy to learning disorders. There seems to be a new philosophy abroad that you do not diagnose unless you can treat; we believe that this is alien to the whole history of medicine.

(5) We are not businessmen and we are bad at deciding whether things are cost effective. We are dismayed though with the fact that community paediatrics is constantly taking the brunt of the cost effective attack and we wonder if the businessmen involved would devote more time to looking at some of the things that go on in hospital and general practice.

References

[1] Bax M. Assessment of the child at school entry. *Pediatrics* 1976;**58**:403–7.

[2] Whitmore K. *Health services in schools — a new look*. SIMP, 1985.

[3] Michelsson K, Ylinen A, Donner M. Neurodevelopmental screening at five years of children who were at risk neonatally. *Dev Med Child Neurol* 1981;**23**:427–33.

Oedema and the aging prima donna

Sir,

It may be a case of the aging prima donna but I was a little disappointed to find that Cartlidge and Rutter in their paper on serum albumin and oedema[1] made no reference to our studies in this field.[2 4] It is of course disappointing to have published work overlooked. However (and perhaps this is the only justification for this letter), our studies included a wide range of measurements of plasma proteins, albumin, and (directly measured) colloid osmotic pressure that might have made useful data for comparative discussion with the Nottingham data. Most particularly I would have been interested to hear their discussion of our apparent findings of a complex relation between plasma proteins, albumin, and colloid osmotic pressure. For all this I do not have any quarrel with the conclusion of their