

habits—it is when a baby sleeps that anxiety levels are highest.

The report emphasises the fact that parents become 'over reliant' and 'more than 50% showed reluctance' to give up monitors. Scales, however, showed an 'advantage in the relative ease with which the tailing off process' could be achieved. Perhaps parents actually preferred the continuing confidence in a monitor—because they know cot deaths occur after 6 months—whereas they readily gave up the difficult and tedious daily weighing procedure.

The report includes a single case report that has been anecdotally quoted in cot death meetings as though it proves that monitoring does not save lives. The case illustrates insensitivity in the conduct of the study—the monitor alarmed very frequently; it was taken away from the baby at 28 weeks and, although the baby had been weighed regularly, a falling weight pattern was not recognised until after the baby had died at 32 weeks. This description suggests that the monitoring aspect of the study was not organised for the primary purpose of supporting parents and at risk infants nor for investigating babies who showed aberrations from normal progress.

The study revealed an expected and worthwhile result—parents are helped most by committed professionals who devote time and caring expertise to their anxieties. The study was not able to show that of the two technical modalities of monitoring, apnoea machines were in any way less successful. One message from the study is that more paediatricians (with help from family doctors, health visitors, and parent groups) should provide expert support services, including apnoea monitors, to those families who have suffered cot deaths.

#### References

- 1 Foundation for the Study of Infant Deaths and the British Paediatric Respiratory Group. Apnoea monitors and sudden infant death. *Arch Dis Child* 1985;**60**:76–80.
- 2 Emery JL, Waite AJ, Carpenter RG, Limerick SR, Blake D. Apnoea monitors compared with weighing scales for siblings after cot death. *Arch Dis Child* 1985;**60**:1055–60.

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Drs Emery, Waite, Limerick, and Carpenter comment: We had objective evidence that indicated that both groups of children had equal morbidity. The apparent lower numbers of symptoms observed by the parents with monitored children could have several explanations, but the one that we passed on came from unsolicited comments of health visitors who had observed the parents' handling of the children in their own homes. Swift writes of 'the difficult and tedious daily weighing procedures'. May be he has some evidence about this, but in the anonymous reports from parents at the end of the surveillance not one parent has made such a comment.

To date our surveillance study has included 300 siblings of cot deaths. Four of these have died; all had been using monitors. Two died while on the monitors and the other two had monitors but were not on them at the time of death. We have had no deaths in the babies on scales

alone. These numbers are of no significance but convince us of the need to continue our studies.

Does Swift believe that two of his 85 children have been saved by the monitors because the mothers believed so? The risk of cot death in a sibling is about one in 200. To prove that apnoea monitors or any other product prevent cot deaths would require a controlled study of a population of around 4000 siblings of cot deaths. At his current case load it would take Swift 116 years to prove the point that apnoea monitors could be saving a life.

In the United States a large number of paediatricians are providing apnoea and cardiac monitors and a recent attempt was made by a group in Los Angeles to evaluate their use in California.<sup>1</sup> They contacted all known monitor programme sites in the state and 30% of these with apnoea programmes and 40% of monitor vendors responded. The information evaluated 3406 infants—1841 having been on home monitors and 1565 not. The cot death rate for California was 1.6/1000 and for the babies on monitors it was 3.8/1000, with a similar rate for those not on monitors. Where there were technical problems with the home monitoring the death rate was 5.7/1000 births. There were 26 deaths in the children surveyed, of which four were due to non-accidental injury. In the California data there was no randomisation of care, thus with all these data the questions are still unanswered. Hence the need for our study.

#### Reference

- 1 Davidson Ward SL, Keens TG, Chan LS, *et al*. Sudden infant death syndrome in infants evaluated by apnea programs in California. *Pediatrics* 1986;**77**:451–8.

## The school entry medical examination

Sir,

I read with interest the article by Drs Whitmore and Bax on the school entry medical examination.<sup>1</sup> Despite the obvious attraction to the parents and teachers of having a doctor pronounce judgment on the normality or otherwise of the 5 year old starting school, the authors fail to make a convincing case for the routine school entry examination, and one must seriously question their continuation from both a scientific and cost effectiveness point of view.

Despite the authors' claim that many socially disadvantaged children do not receive 'satisfactory health surveillance' during their preschool years, there is little evidence to suggest that routine examinations detect health problems that are new findings—that is, were previously unknown and untreated—and/or important—that is, would make an appreciable impact on future health and functioning.

While I strongly support their assertion that clinical interpretation of a neurodevelopmental assessment is more valuable than a score, one cannot assume that other doctors have the same expertise as the authors. Variability in interpretation of results between different doctors might be expected.

The authors do not provide any information on how teachers and parents make use of their findings. Does an

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.<sup>2</sup>

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

- Whitmore K, Bax M. The school entry medical examination. *Arch Dis Child* 1986;**61**:807-17.
- Oberklaid F. The ritual school health examination. An idea whose time has passed? *Aust Paediatr J* 1985;**21**:155-7.

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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).<sup>1,2</sup>

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.<sup>3</sup>

(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

- Bax M. Assessment of the child at school entry. *Pediatrics* 1976;**58**:403-7.
- Whitmore K. *Health services in schools — a new look*. SIMP, 1985.
- 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<sup>1</sup> made no reference to our studies in this field.<sup>2,4</sup> 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