

prescription of human growth hormone, even for this indication, should be controlled by those practitioners experienced in paediatric endocrinology.

- (2) The treatment of patients with other indications should be restricted to carefully designed protocols, within academic units experienced in such research.
- (3) In order to allow long term surveillance of all patients treated with human growth hormone it is desirable that a mechanism to identify all such recipients be set in place such that they will be identifiable in a national register for the foreseeable future.

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ciently with other disciplines and offer training to primary care teams?

- The content of service delivery—are we emphasising prevention sufficiently, and do we work with deprived communities to meet their needs for health care?
- The outcome—do we attempt to measure the effect of our services on deprived populations and provide feedback to those who collect the data?

It would be tragic if the 1980s pass without paediatricians as a group making a concerted response to child poverty and health inequality.

References

- ¹ Wadsworth MEJ. Inequalities in child health. *Arch Dis Child* 1988;**63**:353-5.
- ² Health Education Authority. *The health divide—inequalities in health in the 1980s*. London: Health Education Council, 1987.
- ³ BMA Board of Science and Education. *Deprivation and ill-health*. London: British Medical Association, 1987.
- ⁴ Townsend P, Phillimore P, Beattie A. *Inequalities in health in the Northern region*. Newcastle upon Tyne: Northern Regional Health Authority, 1986.

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Inequalities in child health

Sir,

We turned with excitement to Michael Wadsworth's annotation¹ having awaited a response in the BPA's Journal to the recent reports which have highlighted the dramatic differences in children's health across the social classes and the increasing severity of child poverty in the United Kingdom.²⁻⁴ We were impressed with the evidence of the wide range of measures of health in childhood related to social background that have long term implications. We were disappointed, however, not to find guidance for paediatricians on the causes of the inequalities and on the action we should take individually and as an organisation to redress them.

It will be important to provide accurate evidence of demographic changes in child health, particularly as they affect child nutrition and growth so that the effects of interventions can be evaluated. But surely paediatricians should also look to their response to inequalities now. We suggest that though action should be political and the BPA should make its views clear to government, this is not enough. We must respond through the health service by analysing:

- The structure of our service—is it accessible and meeting people's needs? Do we collaborate suffi-

Phototherapy and the use of heat shields

Sir,

We read with interest the study of Dr Stutchfield and colleagues on the reduction of irradiance which occurs when heat shields are used.¹ In our own unit we had observed the apparently poor response to phototherapy of infants being nursed under transparent thermal blankets ('plastic bubble blanket'), and we therefore carried out measurements of the optical transmission characteristics of three types of bubble plastic including one in regular clinical use.

The measurements were made using a Perkin-Elmer 330 spectrophotometer in combination with an integrating sphere. In the wavelength range 350-700 nm we measured directly transmitted light, scattered transmitted light, absorbed light, and reflected light. The total light transmitted varied from 71% at 350 nm to 77% at 700 nm. At 450 nm, an effective wavelength for the photocatabolism of bilirubin, 74% of the light was transmitted, 26% being lost by absorption or reflection. This reduction in transmitted light is more than twice that reported by Stutchfield *et al.* Possibly, differences in our respective samples could account for this, although it should be borne in mind