

oligosaccharides and other carbohydrates in normal neonates. *Arch Dis Child* 1978;53:913-5.

H BAUMER
Plymouth General Hospital,
Longfield House,
Longfield Place,
Plymouth PL4 7JH

Drs McEnery and Seakins comment:

Certainly, healthy breast fed babies may have frequent loose stools. While it is difficult to define pathological diarrhoea, this infant's diarrhoea was sufficient to get him admitted to hospital despite the adequate weight gain. Both the mother and experienced ward staff felt that the infant's diarrhoea was excessive, despite my attempts to reassure them. Reducing substances were identified in the stools repeatedly, at a concentration of 1%. The diarrhoea immediately resolved on changing to a succession of two other milks (Pregestimil and SMA), and has never returned since. If the baby had continued to be breast fed we do not know whether he would have thrived adequately. His mother declined my suggestion to resume breast feeding. In these circumstances, I believe, it is reasonable to assume that the milk oligosaccharides were responsible for the troublesome diarrhoea (associated with perianal soreness) and that he benefited by the change of milk.

Our observations do not contradict those of Whyte *et al* but underline the importance of diet in the interpretation of analytical findings and of collecting samples before dietary or other therapeutic manipulations.

'... officiously to keep alive'

Sir,

It is good to read articles such as those by Dr Walker and Professor Campbell, which are trying to achieve an appropriate ethical stance in the intensive care of newborn infants.^{1,2} I would entirely agree with Dr Walker that the patient should be treated as a person, the burden being the treatment and not the child. It is poor clinical judgment to continue with onerous and unrewarding treatment. Yet we must also beware of the denial mechanism by which parents and professionals can collude both in giving up too soon or going on too long. A study of perinatal psychology needs to be brought into the ethical debate too.

I also wonder whether it is a correct deduction on Professor Campbell's part to suggest that the incidence of stillbirth associated with spina bifida dropped in the early 1960s only because of the introduction of a more optimistic surgical approach. This could also have correlated with the advent of neonatal resuscitation. It is hard for us to realise now that intubation and ventilation of infants was, at that time, a new skill in the labour ward. We need not paint ourselves blacker than we were!

References

¹ Walker CHM. '... officiously to keep alive'. *Arch Dis Child* 1988;63:560-4.

² Campbell AGM. Commentary. *Arch Dis Child* 1988;63:565-6.

J GOODALL
City General Hospital,
Newcastle Road, Stoke on Trent ST4 6QG

Withdrawal of iodinated disinfectants at delivery decreases the recall rate at neonatal screening for congenital hypothyroidism

Sir,

We recently reported transiently raised serum concentrations of thyroid stimulating hormone during early postnatal life in infants born to mothers whose skin had been disinfected with povidone-iodine (PVP-I) at delivery for epidural anaesthesia or caesarean section.¹ This transient impairment of the thyroid function was particularly severe in breast fed infants with a 25 fold increase in the recall rate at neonatal screening for congenital hypothyroidism, and was attributed to iodine overload due to the appreciably raised iodine content of breast milk in women treated with PVP-I.²

Therefore, PVP-I was replaced in obstetrics by a non-iodinated skin disinfectant (chlorhexidine 0.5% in isopropanolol 70% (CHL)). We compared the frequency distributions of serum thyroid stimulating hormone concentrations at the time of screening in our whole population of healthy breast or bottle fed full term infants, before (n=4745) and during six months after (n=1178) replacement of PVP-I by CHL. We considered separately infants born to mothers without (group 1) or with (group 2) skin disinfection. The table shows that the replacement of PVP-I by CHL entirely abolishes the differences between groups 1 and 2 in: (a) the frequency distributions of neonatal thyroid stimulating hormone concentrations and (b) the recall rate at neonatal screening under suspicion of congenital hypothyroidism (serum thyroid stimulating hormone concentration >50 mU/l) after the type of feeding (levels of significance as compared with group 1: p<0.01). Except for the type of skin disinfectant used in the mothers, the two newborn populations studied presented with identical epidemiological characteristics; consequently, our observations further support the view that iodine overload and transient subclinical hypothyroidism in breast fed infants resulted from the use of PVP-I in the mothers.

In conclusion, iodine overload is a significant and often unrecognised cause of very transient hyperthyrotropinaemia ('false positive') at screening.³ Therefore, PVP-I should be carefully avoided in the neonatal period whenever possible, especially in areas like Belgium where, because of a rather low iodine supply in the population,³ the newborns are particularly sensitive to the antithyroid effects of iodine excess.