

Dr Conway comments:

I am pleased to read of Dr Haque's interest in our paper and apologise for not referring to his work, of which I am aware. None the less, I think it is difficult to extrapolate from his population to ours, for reasons I have already outlined.¹

Dr Haque, in reference to our work, questions the 'justification of giving weekly painful and costly injections'. At the time of the conception and early stages of our study, intravenous immunoglobulin preparations had not received full product licencing in this country. May I remind Dr Haque that our study was approved by the hospital ethical committee and that we would not have given these infants intramuscular injections except as a logical extension of our previous work² and in reasonable expectation of their being of benefit to the child. The cost of prophylactic immunoglobulin treatment, if successful, is more than offset by the saving in expensive antibiotic use.

I absolutely refute Dr Haque's suggestion of possible nursing bias. The substantiation of a doctor's academic hypothesis weighs little with our intensive care nurses compared with the continued well being of their patients. Moreover, in a busy regional unit with much active research in progress, every nurse was not necessarily always aware of which baby was, or was not, receiving immunoglobulin treatment.

The preparation used contained 250 mg in 1.7 ml and volumes injected were therefore small. As stated, injections were at weekly intervals until discharge to home. We were also not surprised that the concentrations of serum IgG were below those of term infants, for reasons similar to those described by Dr Haque. We did not measure IgM concentrations.

References

- 1 Conway SP, Ng PC, McLain B. Immunoglobulin prophylaxis for neonatal sepsis. *Pediatr Infect Dis* 1987;6:581.
- 2 Conway SP, Dear PRF, Smith I. Immunoglobulin profile of the preterm baby. *Arch Dis Child* 1985;60:208-12.

When is meconium stained liquor actually bile stained vomit?

Sir,

In a recent issue of the *Archives*, Griffiths and Burge report three cases of what was initially assumed to be meconium stained liquor but which was actually a manifestation of intrauterine bilious vomiting.¹ They point out that insertion of a thermometer into the rectum, or at least an attempt to do so, would alert people to the possibility of intestinal obstruction resulting in apparent meconium staining of the liquor.

I have seen two neonates, who turned out to have intestinal obstruction, who presented with what was thought to be meconium staining of the liquor. Gastric aspiration in the labour ward produced in excess of 50 ml, and in one case 150 ml, of green liquid. I would therefore like to point out that if meconium staining of the liquor is thought to warrant a laryngoscopy with or without

the insertion of an endotracheal tube it is reasonable also to pass a nasogastric tube and if large volumes of green liquid are obtained from the stomach this suggests that the problem is intestinal obstruction and not in utero passage of meconium.

References

- 1 Griffiths DM, Burge DM. When is meconium stained liquor actually bile stained vomit! *Arch Dis Child* 1988;63:201-2.

N ARCHER
John Radcliffe Hospital,
Headington,
Oxford OX3 9DU

Facts for teachers of children with cancer

Sir,

The valuable paper by Dr Stevens and colleagues raises important issues.¹

- (1) Teachers should be more informed in a general sense, in as much detail as they themselves would find helpful, about conditions such as malignant disease, cystic fibrosis, and diabetes (the most obvious examples) which can have a pervasive effect on the well being of children in school.
- (2) As an important general rule (to which there may be exceptions in individual circumstances), teachers should not be given medical details about individual children. The confidentiality aspects of passing on such information cannot be controlled in mainstream or even special schools in the way which is presumably practicable in the context of teachers' work in the health services dominated environment of a hospital.

Doctors who do not work regularly in schools may be unaware of the extent to which educational records are increasingly 'open', with corresponding availability to staff of any medical information in writing which goes to the school, and the encouragement of informal exchanges of information. Medical matters tend to fascinate large numbers of the non-medical public, including professionals, and we can neither expect nor monitor an adequate level of respect for the confidentiality of certain information in non-medical environments such as schools. A 13 year old girl with advanced malignant disease was quoted recently on television as saying that 'everybody' at her school knew about her condition and its implications, and that this single circumstance caused her more misery than anything else.

- (3) Dr Stevens *et al* quote the British Paediatric Association *Report on the school health services*,² but do not directly mention the school health service. In my view a relevant school health service could and should make it its business to provide appropriate support and advice to schools and individual teachers as necessary about individual children, which implies close links between