specialists give to general practitioners, children, and parents.' Thus for the sake of all children with asthma, all the participants put in an enormous effort to produce the document. Of course it will require modification in the future and no doubt there will continue to be some disagreement between experts on some of the finer points of management. However, general practitioners and paediatricians without the extra insight of paediatric respiratory physicians do need some basic guidelines to follow. It was also appreciated that there would be some regional differences. As such the Australian paediatric respiratory physicians have already modified the document for local national consumption. They, in fact, have decided to exclude theophyllines completely as being totally unacceptable at any age in the management of asthma and were also unhappy about the use of any other oral bronchodilator. However the remainder of the document was accepted.

The document also clearly outlines that there is virtually no controlled trial evidence of the efficacy of any treatment in children under the age of 1. Thus any judgments on management at this age are best based on clinical experience and anecdotes. It was this age group that generated the greatest discussion in the meeting. However for the remainder, it was accepted even by paediatricians from those countries with a strong inclination to use theophyllines, that they should be demoted to a secondary role in management with the inhaled prophylactic compounds being preferred. When accounting for the costs of the use of treatment, one must also consider the need for monitoring, which of course is essential with theophyllines because of the narrow therapeutic index. However, by comparison there is an enormous margin of safety with the use of the inhaled compounds.

Dr Costain was invited to respond to the letter by Professor Godfrey:

In his letter Professor Godfrey raises several issues which are familiar concerns for those involved in organising consensus conferences and statements. The King's Fund Centre has been organising national consensus conferences since 1984 and has now published statements covering a wide range of issues. It has never been the intention, either explicitly or implicitly, for these to be prescriptive nor had it ever been suggested that the recommendations reflect the only approach to a particular issue. Rather they are statements of what appears to be the best approach given the current state of knowledge. As far as I am aware this is true for consensus statements produced elsewhere and where such statements suggest clinical protocols, they have usually explicitly allowed for deviations to the recommendations to be made where appropriate by clinicians.

On the question of bias, it is not only commercial interests which one has to guard against. We always take considerable care that all interested opinions are considered, although the panel itself clearly has the responsibility for deciding the final recommendations.

There is wide support, both in the United Kingdom and abroad, for the consensus approach to complex or con-

troversial issues. It would be regrettable if fear of misuse were to make production of such statements more difficult.

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Prognostic value of creatine kinase BB-isoenzyme in high risk newborn infants

Sir,

We read with interest the report by Ruth on the prognostic value of creatine kinase BB-isoenzyme (CK-BB) in the newborn infant.¹ We have studied 14 infants with birth

Figure Serum CK-BB concentrations in asphyxiated (open circles) and very low birthweight (closed circles) infants categorised by outcome, compared with 24 term control infants (crosses). The upper 95% confidence interval derived from the control group is shown.

asphyxia (those with an Apgar score at 5 minutes <6 or signs of hypoxic ischaemic encephalopathy, or both), 37 very low birthweight infants (<1500 g), and 24 control infants and measured their serum CK-BB concentrations in the first day of life by a two site radioimmunoassay.² Neurodevelopmental follow up, including a Griffiths's developmental assessment, was performed at 12–24 months' corrected age. Outcome was graded as 'abnormal' (developmental quotient <75 or definite neurological abnormalities), 'equivocal' (developmental quotient 75–85 or soft neurological signs), or 'normal'. Fourteen very low birthweight and six asphyxiated infants died. In the very low birthweight infants the concentrations of CK-BB in those who died (geometric mean $13.3 \mu\text{g/l}$, 95% confidence interval 6.7 to $26.3 \mu\text{g/l}$) were significantly higher than those who survived (geometric mean $4.5 \mu\text{g/l}$, 95% confidence interval 2.4 to $8.3 \mu\text{g/l}$), $p<0.05$. If only survivors were considered there was little discrimination of outcome in very low birthweight or asphyxiated babies. The upper

95% confidence interval for the control infants was $32 \mu\text{g/l}$, and if this is taken as the upper limit of normal then there was no non-random association between abnormal CK-BB concentration and outcome (figure).

We would concur with Ruth that high concentrations of CK-BB on the first day of life may be predictive of death but are not a useful indicator of outcome in survivors.

References

- ¹ Ruth VJ. Prognostic value of creatine kinase BB-isoenzyme in high risk newborn infants. *Arch Dis Child* 1989;**64**:563–8.
- ² Jackson AP, Siddle K, Thompson RJ. Two-site monoclonal antibody assays for human heart- and brain- type creatine kinase. *Clin Chem* 1984;**30**:1157–62.

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