extend their knowledge of basic sciences (epidemiology, statistics, sociology as well as developmental paediatrics) but also they will require insight into organisational structures, together with communication and assertiveness training to help fulfil their true position as public health advocates for school children. 4

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Iron supplementation in the preterm or low birthweight infant

SIR,—In September of 1988 we carried out a similar survey to that of Barclay et al.1 by telephone, contacting 26 British neonatal units with more than four intensive care cots. It appears that the two surveys have similar results: the statistical modes for the dose of iron supplement, the time of initiation, and duration of treatment are identical. However, we reached a different conclusion. In view of the recommended supplement given by the European Society of Paediatric Gastroenterology and Nutrition or the American Academy of Pediatrics, the majority of neonatal units oversupplement their patients. Although there is no reported difficulty associated with these larger oral supplements, if taken in conjunction with transfused iron, it is conceivable that the raised iron load will increase susceptibility to infection, and potentiate other pathologies via free radical mechanisms in a small or premature neonate. 3 Therefore on the basis of primum non nocere we concluded that iron supplements should be reduced to the level of current recommendations, and the sequences carefully monitored.

In our survey we further identified another complication associated with iron supplements: in two units iron and phosphate supplements were given to patients during the same drug round. This combination produces an insoluble complex, rendering both supplements ineffective.

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Arteriovenous malformations in the vein of Galen

SIR,—We enjoyed reading the annotation on arteriovenous malformations of the vein of Galen by Dr Nicholson et al. 1 In the annotation reference was made to our case report of a newborn with a pattern I lesion who had her severe congestive heart failure treated by embolisation of the malformation using Gianturco coils. 2 Nicholson et al suggested this procedure is a useful interim measure allowing elective surgery to be carried out when the child is older and fitter.

In our case, however, we reported a successful outcome to the age of 21 months with normal growth and development. 3 Indeed, our little girl is now 4 3 years old and appears perfectly normal, without any additional procedures having been necessary.

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Increases in plasma concentrations of a prostaglandin metabolite in acute airway obstruction

SIR,—Skoner et al elegantly demonstrated raised plasma concentrations of a prostaglandin metabolite during and after recovery from acute airway obstruction in infants. 4 They suggested that prostaglandin F2α is involved in airway obstruction and therefore encourages trials of specific anti-inflammatory agents for the treatment of airway obstruction.

There are, however, some disturbing data in the article that should preclude assuming any causal relationship between prostaglandins and airway obstruction in these studied infants. The authors have not actually found any difference in prostaglandin concentrations between infants studied shortly before and those studied shortly after initial treatment. They have not demonstrated such a difference in the few infants whose prostaglandin concentrations were measured before and shortly after airway obstruction (shown in fig.). It is also not clear from the data whether group II (infants after treatment) had their airway obstruction resolved at the time of blood collection.

In order for an appropriate correlation between prostaglandin plasma concentrations and airway obstruction, more objective parameters (lung function tests) need to be studied rather than the clinical assessment used in this study. Furthermore, airway obstruction such as described was probably associated with a marked degree of stress. Hypoxaemia may have been present as well. The possibility also exists that prostaglandins are released into the circulation in response to bronchoconstriction. Tachypnoea, bronchocostriction, hypoxaemia and stress are all factors that should be excluded as a possible cause for prostaglandin secretion. Thus it is still to be determined whether prostaglandins play a mechanistic role in airway obstruction or whether their increases are merely a morphological marker for some other aspects of the acute clinical situation.

Treatment directed against byproducts of