mothers had low serum α-fetoprotein had left sided diaphragmatic defects; one died before surgery; two had surgery, of whom one died and one survived.

It has been suggested that low maternal serum α-fetoprotein in congenital diaphragmatic hernia may be due to liver herniation into the chest resulting in decreased hepatic production or secretion of α-fetoprotein.5 Liver herniation occurred in only two of our three patients whose mothers had low serum α-fetoprotein and therefore is unlikely to be the sole explanation of this observation. None of our three patients whose mothers had low serum α-fetoprotein had antenatal diagnosis of congenital diaphragmatic hernia by ultrasonography. Our experience suggests that low maternal serum α-fetoprotein has a definite but limited role as an adjunctive investigation to ultrasonography in the antenatal diagnosis of congenital diaphragmatic hernia.

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Clinical monitoring of steatorrhoea in cystic fibrosis

SrR,—Walters and colleagues, comparing methods of assessing steatorrhoea in cystic fibrosis,1 attributed the steatocrit test to Colombo.2 The correct attribution is Phuapradit3 and so their claim to have used the method 'exactly as originally described' is not substantiated.

Phuapradit et al published the steatocrit as a method for assessing fat excretion in the newborn. If applied to the older child on a mixed diet, particularly if the subject is malabsorbing (the method may not show whether or not these subjects were receiving pancreatic enzyme supplements during the study), the stool homogenisation technique becomes crucial. A fine tolerance Porter-Evelhoch homogeniser is essential for satisfactory dispersal of stool solids and the homogenate water content must be higher than that used by Phuapradit and colleagues. Once established, the conditions for homogenisation and centrifugation must be scrupulously observed. Walters et al thought them insufficiently important to give details of either step and it is not surprising therefore that serious technical difficulties were experienced. The steatocrit cannot be dismissed on this evidence.

The other semi-quantitative stool fat method assessed was microscopy of stool homogenate after lipid staining (a subjective assessment but apparently not done blind). It produced a specificity of 55% or 46% depending on whether the two normal fat excretion limits quoted are accepted (20 mmol/day in the text, 17-5 mmol/day in figs 1 and 2). Most children with cystic fibrosis achieve normal or near normal fat excretion when given microencapsulated enzyme supplements but half such children would be indicated for further investigation or increased enzyme dosage by the microscopy method. The authors' enthusiasm for the test is therefore not warranted and it would not, as was suggested, identify the non-compliant for there would be no way of differentiating the latter from a poor responder. Those who spend their working days contemplating stools understand the need for an alternative to the 72 hours fat excretion test. The 'bluebird' still eludes us.

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4 Drs Walters, Kelleher, and Littlewood comment.

Thank you for the opportunity of replying to the letter of Drs Brown and Booth relating to our recent publication.1 We are grateful to them for pointing out our error in stating that the steatocrit method was carried out as originally described. In fact, what should have been stated was that the method was carried out as described by Colombo et al, though it must be stated that methodological details in that paper were indeed sparse.2 All homogenisations, after addition of two volumes of water, were carried out in a Waring blender at 12 500 rpm for five minutes. Centrifugation details are given in our paper and both these conditions were standardised for the results published. As stated in our paper, various technical changes were attempted to improve the method, but with little success, and we have no explanation for this. We have not dismissed the steatocrit method but would repeat that, whatever the reason, 'in our hands this method would not serve as a screening test'.

We do agree that microencapsulated pancreatic enzyme preparations greatly improve the control of fat malabsorption in cystic fibrosis. In the trials so far published, however, a considerable proportion of patients remain with appreciable steatorrhoea, and identification of these patients is important. In our clinic, where over 160 patients taking these enzyme preparations have had regular faecal fat assessments, about 20% remain with significant steatorrhoea. Whether continuing malabsorption is due to a poor response to treatment or non-compliance is difficult or impossible to assess, but the presence of continuing severe steatorrhoea, which will be reliably demonstrated by the simple microscopic screening test, will alert the physician to investigate both possibilities.

Happily we do not spend our working days contemplating stools, but we would agree that an alternative to timed faecal collections is needed, particularly in cystic fibrosis where regular monitoring of fat malabsorption may be required. However, in our hands the steatocrit method was certainly not the elusive 'bluebird'. The microscopic fat method does, however, have some flight in it and does exclude severe steatorrhoea but neither this indirect method, nor any other presently available, will quantify the severity of fat loss and we would certainly not make this claim.

Patients who do not come

Sir,—Stamps are cheaper than visits. Instead of a further appointment, mothers can be invited to write to news of the child, most effectively on an easily remembered day such as a birthday, half term, or G Frye. But at any time if there is concern. An addressed envelope, perhaps stamped free of charge, as a reminder. The least literate letters are often the most informative, and no news is good news. The letter of thanks from the doctor is not a functionary, can offer another appointment if necessary.

New patients who fail to come can be invited the next week by a personal letter asking them to confirm the booking by telephone. So that it may be offered to another child if necessary. If there is no response, the referring doctor is told.

Paediatricians rarely have unplanned waiting lists for admission. We can be worth telephoning to ask if a proposed admission date is convenient before sending it.

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Monitoring and sudden infant death syndrome

SrR,—We are disappointed with your recent article on home monitoring and sudden infant death syndrome.1 On average between five and 10 infants at risk of sudden death are referred each week to our department by their consultant paediatrician or family practitioner for investigation and management. The latter includes a home monitoring programme that involves the use of transcutaneous oxygen pressure (PO2) monitors and this is well known to the Foundation for the Study of Infant Death and to the other authors of your article. We have presented our results at national (paper presented at joint meeting of British Paediatric Respiratory Group and Foundation for Study of Infant Death, Liverpool 16 September 1988) and international2 conferences concerning sudden infant death.

The 'bluebird' we wanted, the article dismissing transcutaneous PO2 monitoring in the home is not based on experience but on prejudice following its use in neonatal units. In contrast, we have experience in over 250 infants with the use of this monitor in the home for periods up to 13 months (mean (SD) 6.4 (2.6) months). Unlike breathing movement detectors, this monitor is 100% sensitive to hypoxic episodes. It has infrequent false alarms (one every six days) compared with an average of six per day for monitors based on impedance pneumography and electrocardiography.

In our experience, the PO2 monitor does not cause skin burns (sensor temperature 43°C, recommended resting interval eight hours), has a median total response time of 21
seconds to hypoxemia (oxygen saturation less than 60%) and baseline transcutaneous PO₂ values are reproducible from sitting to sitting. In addition this monitor may also detect other potential causes of life threatening events where there is peripheral vascostenosis due to metabolic shock or low cardiac output, although this function has yet to be fully validated.

Pulse oximetry was given more support than transcutaneous PO₂ in your article. In our experience, the former is much too prone to movement artefact to use at home. Exceptional alarms are common and occur when the infant has normal body movements (false positives). Of more concern is the failure to alarm which may occur when these movements arise in association with cyanotic episodes (false negatives).

All infants in our programme are supervised closely by doctors and clinical nurse specialists. The project is funded by three charities as well as the Department of Health and the National Heart and Chest Hospitals. The Foundation for the Study of Infant Death is one of a number of charities that help partially to fund and support research into the mechanisms responsible for sudden infant death. In our opinion, the views given in your article on home monitoring should have been balanced by the experience of charities and departments who have used transcutaneous PO₂ monitors in the home.

Dr S. Davies, Milner, Silverman, and Simpson comment: Dr Southall and his colleagues have missed the point. Our report "Monitoring and sudden infant death syndrome: an update" considered the published information that was available to us at the time, and attempted to relate that information to the topic of sudden infant death. Their letter has failed to provide any objective evidence, as opposed to opinion, that transtundane oxygen monitoring is more effective than pulse oximetry.

Early diet in preterm babies and development status in infancy

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Access for peritoneal dialysis in neonates and infants

Sir—Lewis et al describe the use of a tapered polyurethane catheter which can be introduced into the abdomen under the guidance of the Seldinger technique to provide access for acute peritoneal dialysis in small infants. They argue that the method of introducing the cannula makes the technique safer than using a stylet to occlude, but describe no instance of problems including the death of one baby after the catheter eroded through the gut wall.

We agree that the Seldinger technique is the safest method of introducing peritoneal dialysis catheters at any age, but we believe the Tenckhoff catheter which we use has major advantages over other designs. Although Lewis et al describe the "Pendlebury" catheter as being "soft and pliable", it is designed to be stiff enough to be "forced through the skin with a 'screwing' action" and it tapers to a tip of about 1.5 mm diameter. By contrast, the Tenckhoff has a very soft silicone external cuff which reduces the risk of it causing perforation to be negligible. They are designed for permanent peritoneal dialysis and are available as a French size (FG) 14 Freyman catheter (FG 12 Freyman) and are available for long-term use with side holes extending to between 3 and 15 cm from the tip, and as 'cuffed' catheters with holes extending 20-5 cm along a helical end of approximately 6 cm diameter.

Although Tenckhoff catheters are usually inserted surgically, they may be introduced percutaneously using a technique similar to that described by Lewis et al but with some modifications. We apply general anaesthesia (as EMLA cream, Astra) to the site one hour before the procedure which is done with sedation, analgesia, and infiltration of local anaesthetic. A small skin incision is made using a number 15 scalpel blade used vertically to project a cut of no more than 3.5 mm, to avoid leakage. The opening is then gently dilated using artery forceps. It is not necessary to use two needles in order to introduce fluid and to pass a wire as Lewis et al describe, as there are cannulas that are designed to fulfill both roles (two part needle, Kimal). With about 30 ml/kg fluid in the peritoneum the peel away sheath and its introducer are simply inserted into the abdomen in a similar way to the Pendlebury catheter. The sheath itself is a thin walled plastic outer catheter rather like a drinking straw, to which a cannula groove each side along its inside surface, and two moulded wings at the top. Once the introducer is in the abdominal cavity the sheath can be slid onward over its tip, and the introducer and the wire removed. The Tenckhoff is then slipped through the lumen of the sheath into the abdomen. At this point the wings of the sheath can be snapped apart and the two halves of the sheath easily torn apart along their length. The Tenckhoff is advanced simultaneously, until the sheath is pulled completely out of the patient as two separate halves.

Tenckhoff catheters are available with and without Teflon cuffs which are designed to be buried beneath the peritoneum and in subcutaneous tunnels, when used as a permanent catheter. We use a cuffed design to aid safe anchorage of the catheter by inserting a skin stitch about 1 cm from the entry site and tying the stitch around the cuff (as far outside the patient); this provides a firm grip for the tie. The catheter can then be cut to any convenient length and the connector inserted.

We have used standard (16 FG) diameter Tenckhoff in newborns, but not in the