Clayton had low serum α-fetoprotein and low serum lipid was observed. Walters and colleagues, comparing methods of assessing steatorrhoea in cystic fibrosis, attributed the steatocrit test to Colombo. The correct attribution is Phuapradit 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 subject would not eat as much), one can have no explanation for this. We have not dismissed the steatocrit method but would repeat, whatever the reason, 'in our hands this method would not serve as a screening test'.


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Monitoring and sudden infant death syndrome

Sir,—We are disappointed with your recent article on home monitoring and sudden infant death syndrome. On average between five and ten 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 international conferences concerning sudden infant death.

The new 'delicate' test referred to in 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