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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Clinical monitoring of steatorrhoea in cystic fibrosis

Mr. 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. 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 without 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 steatorrhoea and 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

SR,—Stamps are cheaper than visits. Instead of a further appointment, most can often be invited to write with news of the child, most effectively on an easily remembered day such as a birthday, half term, or Guy Fawkes, but at any time if there is concern. An address envelope, perhaps stamped with a NHS letter 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 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, 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 ‘steel’ key we need for 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.1

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