Dr Taylor and Emery comment:
The main differences between the Bristol and Sheffield views on unexpected infant deaths are, firstly, that the Bristol group do not accept the concept that several contributory factors may result in a lethal situation, and secondly that they are unable to accept that filicide is the probable cause of a small percentage of cot deaths.

Our view is that many unexpected infant deaths are due to a combination of factors in the home for the presence of all of these factors death might not have occurred.1 The concept of contributory factors is one which is generally accepted—for example, the increased severity of infections in children who are being treated for deficiencies may result in reduced pulmonary reserve due to residual lesions in the lung after perinatal damage. Dr Fleming and his group have themselves postulated that overheating and overheating may be a contributory factor in some cot deaths.2

The confidential inquiries undertaken by Dr Fleming and his group with case conferences being hospital based and hospital orientated are very similar to those undertaken in Sheffield in the 1970s, and their results are very similar to our own at that time. In 1979 we started to hold our case discussions on all ‘non-hospital’ deaths in the family doctor’s surgery. These case discussions are held when data collection, including a home visit by a doctor not concerned with the paediatric care of the family, is complete and the results of a full paediatric necropy are available and at a time when the initial emotional impact of the death is lessening and more dispassionate views may prevail. These discussions, at which the general practitioner and health visitor are invariably present, are as much concerned with planning for the future health care of the family and of any subsequent child as with the cause of the baby’s death. Thus, confidential discussions with the general practitioner and health visitor who have revolutionised our views on the aetiology of unexpected infant death and have shown us the importance of family and background factors, and it is at these discussions that the possibility of filicide is occasionally raised. Deaths are only placed in this category if at the conclusion of the case discussion it is a unanimous view that the confidential discussions with the general practitioner and health visitor—can be provided for the family. Although the identification of possible filicide only forms a relatively small part of our inquiries, the possibility of this mechanism of death would also deny some families the extra care that they need. Fleming et al state that our data should be inspected by an independent group of paediatricians and pathologists. As we collect more than 50 pages of data after each death this would be a major undertaking. However, we have no secrets other than the confidential-
with progression to haemolytic uraemic syndrome (p=0.414), and gender was not a significant predictor variable in multivariate analysis. Our studies do not, however, include an analysis of the effect of gender upon the severity of haemolytic uraemic syndrome.

Although the potential for young age and prolonged use of antimotility agents to enhance the progression of E coli 0157:H7 enteritis to haemolytic uraemic syndrome might be explained on the basis of a toxin per body weight relationship, the designation of female gender as a risk factor might lead to alternate views on disease pathogenesis—for example, a gender difference for toxin receptors. Therefore, future studies should critically evaluate gender in the context of appropriate control groups.

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Ready, steady, hiss

SIR,—Working in a Cambodian refugee camp reminded me how important both definitions and cultural influences are in timing developmental landmarks. In Britain control of micturition implies that the child recognises his full bladder and communicates this to the carer, a process attained by the majority at 1.5 years.

In the camp where there are no nappies and infancy is spent attached by a large sheet to the mother's side, however, mothers have developed a technique for toiletting their infants at an earlier age that prevents themselves being wet all day, and may have unknowingly shone new light on the mechanisms of toiletting. When the suspects that her infant's bladder is full, the mother hisses in her ear as she holds her in a squat position over the earthen floor. By between 6 and 12 months of age this hiss initiates prompt bladder emptying.

Little is known of the psychological basis for toiletting, but if these observations are correct, then at least here classical (pavlovian) conditioning may have a role, in which the conditioned stimulus is the hiss, the unconditioned stimulus is the full bladder, and the response is the bladder emptying. At first sight this technique is reminiscent of the toiletting history of B F Skinner,1 the great proponent of operant conditioning in behaviourist theory, who was successfully toileted by 9 months on a potty chair that played 'The Blue Danube' when she produced! Such music may be considered pleasant to the infant and, therefore, suggestive of operant conditioning because it provides an incentive to urinate appropriately. The case for my description being classical conditioning rests on the hiss of the mother being a neutral stimulus that is neither an incentive nor a deterrent to the infant in urinating (as neutral as the bells were to Pavlov's dogs).

I see no reason why this technique should not be studied further, and if found to be effective, may greatly help mothers involved in the exhaustion of nappy changing, regardless of which school of psychology this phenomenon supports.

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Terminology in community child health

SIR,—Dr Stone's annotation on terminology in community child health was a useful airing of an important issue. He lists the definitions he proposes are clear and acceptable.

I have two points to make. Firstly, the definition of surveillance he proposed concerns a limited and a relatively small proportion of the work currently carried out by child health doctors and general practitioners in child health clinics. In many ways, restricting the definition of surveillance to cover the 'collection . . . and interpretation of indices of child health, growth, and development' is useful as it is near to the accepted lay definition of surveillance. However it should be made clear that this is different to the commonly known as child health surveillance as described in the Court report1 and more recently in the Hall report.1 The latter consists of a much wider ranging activity, the emphasis of which is on the promotion of health and development with the implied active participation of parents in the process. The inappropriateness of the word 'surveillance', in terms of its connotations, for this activity was commented on in the Hall report but no suitable alternative was suggested.

The second point concerns Stone's patronising view of community paediatrics as a rather cosy, anachronistic, and insular specialty which, he states, feels uncomfortable at being neither in the main stream of hospital paediatrics or public health. I would refute this suggestion strongly. The Court report recommended a consultant led community child health service, of the sort that is currently emerging, as the best hope for improving standards of child health to all sections of the population. The working practices in community child health that have evolved since then are positive, effective, and in many cases, novel approaches to the problems of improving and integrating health services for children. That controversy exists, even surrounding terminology, is a measure of the innovatory nature of much of community paediatrics. Rather than seeing community child health 'trapped in a professional and organisation vacuum' I would see it as a model for other health services such as geriatrics, psychiatry, and even other obstetrics, which still remain hospital and medically orientated despite the problems often being community related.

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Use of peripheral vessels for exchange transfusion

SIR,—I would like to congratulate Fok et al for reminding us again in a documented way that there is no need for exchange transfusions to be carried out 'the conventional way'. For the past six to seven years we have also used peripheral vessels for exchange transfusions as the preferred route particularly in ill preterm infants, and I would entirely concur with the authors' comments on safety issues. I would like to recommend a modification of their technique, however, which requires only one operator/observer, an important advantage for a busy neonatal unit. Two syringe pumps are required. The first is used to deliver blood through the peripheral vein. The second is modified and its action is reversed (that is, it pulls the syringe plunger) and is used to withdraw blood through the peripheral artery at the same rate chosen for the former. If such a modification is impossible then the operator withdraws blood through the artery at precisely the rate of the syringe pump. By using two syringe pumps, however, the movement of the plunger is more even and smoother and the likelihood of extravasation of blood and arterial spasm is minimised. There is one potential action that I believe needs to come to the attention of the baby and let 'the system run on its own.'

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Reflux vomiting

SIR,—In his comprehensive review of reflux vomiting Dr P J Mills suggests that the prone head raised position is the most effective therapeutic position and cites references to support this.1 Yet in the first direct comparison of the prone flat and prone head raised (30 degrees) positions it has been shown that the flat position is just as effective.2 This is an important practical observation. In the past, by a variety of methods, much effort has been spent maintaining infants in the raised position which we now know to be unnecessary. This is good news for both nurses and parents!
