with progression to haemolytic uraemic syn-
drome (p=0.414), and gender was not a signif-
ificant predictor variable in multivariate ana-
lysis. Our studies do not, however, include an
analysis of the effect of gender upon the sever-
ity of haemolytic uraemic syndrome.

Although the potential for young age and
prolonged use of antimotility agents to en-
hance the progression of E.coli 0157:H7 enter-
toxin 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 recep-
tors. Therefore, future studies should criti-
cally evaluate gender in the context of appro-
riate control groups.

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1 Milford DV, Taylor CM, Guttridge B, Hall SM,
Rowe B, Kleanthous H. Haemolytic uraemic
syndrome: a British Isles 1993–8; associa-
tion with Verotoxycytotoxin producing Escherichia
coli. Part 1: clinical and epidemiological

2 CIMOLAI N, Carter JE, Morrison BJ, Anderson
JD. Risk factors for the progression of Escher-
ichia coli 0157:H7 enteritis to haemolytic-

Ready, steady, hiss

Sir,—Working in a Cambodian refugee camp
reminded me how important both definitions
and cultural influences are in timing develop-
mental landmarks. In Britain control of mici-
turbation 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 devel-
oped a technique for toiletting their infants at
an earlier age than 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 his ear as she holds
him 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 physiological basis
for toiletting, but if these observations are cor-
rect, then at least here classical (pavlovian)
conditioning may have a role, in which the
conditioned stimulus is the hiss, the uncondi-
tioned 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 classical (pavlovian) behav-
ourism, 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, supportive of operant condi-
tioning because it provides an incentive to
urinate appropriately. The case for my
description being of 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, regard-
less of which school of psychology this pheno-
menon supports.

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1 Skinner BF The shaping of a behaviourist. New

Terminology in community child health

Sir,—Dr Stone’s annotation on terminology
in community child health was a useful airing
of an important and, in my view, large,
problem that definitions propose are clear and
acceptable.

I have two points to make. Firstly, the
definition of surveillance he proposed con-
cerns a limited and a relatively small propor-
tion 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 ‘col-
lection . . . and interpretation of indices of
child health, growth, and development’ is
useful as it is near to the accepted lay defini-
tion of surveillance. However it should be made
clear that this is different to an activity
known as child health surveillance as described in
the Hall report1 and more recently in the
Health report.2 The latter consists of a more
wide 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 connota-
tions, for this activity were commented on
in the Hall report but no suitable alternative
was suggested.

The second point concerns Stone’s patronis-
ing view of community paediatrics as a rather
cosy, anachronistic, and insular specialty
which, he states, feels uncomfortable at being
neither in the mainstream of hospital paedia-
trics or public health. I would refute this sug-
gestion strongly. The Hall report recom-
ended a consultant led child community
child health service, of the sort that is currently
emerging, as the best hope for improving stan-
dards of child health to all sections of the
population. The working practices in com-
unity child health that have evolved since
then are positive, effective, and in many cases,
novel approaches to the problems of impro-
vancing and integrating health services for
children. That controversy exists, even sur-
rounding terminology, is a measure of the innova-
tory nature of much of community paediat-
rics. Rather than seeing community child
health ‘trapped in a professional and organisa-
tional vacuum’ I would see it as a model for
other health services such as geriatrics, psychi-
atria, and even peri-natal obstetrics, which
still remain hospital and medically
oriented despite the problems often being
community related.

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1 Stone D. Terminology in community child
health—an urgent need for consensus. Arch Dis

2 Report of the Committee on Child Health
Services. Fit for the future. London: HMSO,
1976. (Court report.)

3 Hall DMB, ed. Health for all children. A pro-
gramme for child health surveillance. Oxford:

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 transfu-
sions to be carried out ‘the conventional way’3.

For the past six to seven years we have also
used peripheral vessels for exchange transfu-
sions as the preferred route particularly in ill
preterm infants, and I would entirely concur
with the authors’ comments about transfusion.
I would like to recommend a modification
of their technique, however, which requires
only one operator/observer, an important
advantage in a busy neonatal unit. Two spring
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 periph-
erylateral 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. This
is the only potential disadvantage of tech-
ition to move away from the baby and let ‘the
system run on its own.’

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1 Fok TF, So LY, Leung KW, Wong W, Feng
CS, Tsang SS. Use of peripheral vessels for
exchange transfusion. Arch Dis Child 1990;65:
676–8.

Reflux vomiting

Sir,—In his comprehensive review of reflux
vomiting Dr P J Milla suggests that the prone
head raised position is the most effective ther-
apetic position and cites references to sup-
port 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 posi-
tion which we now know to be unnecessary.
This is good news for both nurses and parents!

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1 Milla PJ. Reflux vomiting. Arch Dis Child

2 Orenstein SR. Prone positioning in infant gastro-
osophageal reflux: is elevation of the head