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.

N CIMOLAI
Division of Medical Microbiology, Department of Pathology

J E CARTER
Department of Paediatrics, British Columbia's Children's Hospital,' Vancouver, British Columbia, Canada V6H 3V4

1 Milford DV, Taylor CM, Guttridge B, Hall SM, Rowe B, Kleanthous H. Haemolytic uraemic syndromes in the British Isles 1985–8: association with Verocytotoxin producing Escherichia coli. Part 1: clinical and epidemiological aspects. *Arch Dis Child* 1990;65:716–21.
2 Cimolai N, Carter JE, Morrison BJ, Anderson JD, Risk factors for the progression of Escherichia coli 0157:H7 enteritis to hemolytic-uremic syndrome. *J Pediatr* 1990;116:589–92.

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 toileting their infants at an earlier age that prevents themselves being wet all day, and may have unknowingly shone new light on the mechanisms of toileting. When she 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 psychological basis for toileting, 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 toileting history of B F Skinner,[1] the great proponent of operant conditioning in behaviour 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, supportive of operant conditioning 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, regardless of which school of psychology this phenomenon supports.

C G M RICHARDS
30 Park Road, Watford, Hertfordshire WD1 3QN

1 Skinner BF *The shaping of a behaviourist*. New York: Knopf, 1979.

Terminology in community child health

SIR,—Dr Stone's annotation on terminology in community child health was a useful airing of an important issue.[1] By and large, 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 activity known as child health surveillance as described in the Court report[2] and more recently in the Hall report.[3] 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 connotations, for this activity were 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 organisational vacuum' I would see it as a model for other health services such as geriatrics, psychiatry, and even perhaps obstetrics, which still remain hospital and medically orientated despite the problems often being community related.

RICHARD F READING
Beaconhill Children's Centre, 163 Langdale Drive, Cramlington, Northumberland NE23 8EH

1 Stone D. Terminology in community child health—an urgent need for consensus. *Arch Dis Child* 1990;65:817–8.
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 programme for child health surveillance*. Oxford: Oxford University Press, 1989.

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'.[1]

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 and conclusions. 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 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 only one potential hazard. The temptation to move away from the baby and let 'the system run on its own.'

H D DELLAGRAMMATICAS
Neonatal Intensive Care Unit, 2nd Department of Paediatrics, University of Athens, Aglaia Kyriakou Children's Hospital, Athens, Greece

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 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!

I BLUMENTHAL
The Royal Oldham Hospital, Rochdale Road, Oldham OL1 2JH

1 Milla PJ. Reflux vomiting. *Arch Dis Child* 1990;65:996–9.
2 Orenstein SR. Prone positioning in infant gastro-oesophageal reflux: is elevation of the head worth the trouble? *J Pediatr* 1990;117:184–7.