

chapter on the role of general practice in child care.

I have mentioned just a few of the enormous number of ideas in this book. It is well presented and contains references up to 1990. As today's subspeciality work becomes part of tomorrow's general paediatrics all those involved in child care will find it very useful. The editors and authors are to be congratulated and so is the Royal College of Physicians.

M MONCRIEFF
Consultant paediatrician

Pediatric Decision Making. 2nd Ed. by Stephen Berman. (Pp 480; £39.50 hardback.) B C Decker Inc, 1991. ISBN 1-55664-141-9.

Although not the sort of book that you can leaf through idly in free moments between bathing the baby and writing your MD, it is a very comprehensive approach to paediatric management. Written as a series of flow diagrams, it gives clear and sensible guidelines on common paediatric problems. It is divided into 14 sections according to systems and includes a section on behavioural and developmental disorders. Each section is further subdivided into chapters based either on presenting symptoms or on a presumed diagnosis. Important points to be covered in the history and examination are outlined, investigations are suggested according to the severity of the illness, and flow diagrams guide the reader through a logical sequence of management decisions, including follow up. All suggested drugs are listed at the ends of chapters together with dosages and availability. For simplification, diagrams are annotated separately on facing pages.

As it is an American book there are, of course, differences in names of drugs and recommended treatments. For example, subcutaneous adrenaline is still a commonly used first line bronchodilator in America where it is prescribed as subcutaneous epinephrine. In addition there are differences in our antibiotic prescribing policies and anyone using this book should be aware of their local policy, particularly when prescribing first line antibiotics for undiagnosed septicaemia or meningitis.

Every registrar should keep this useful book on hand for reference should they wish to appear intelligent to their senior house officers, especially from the end of the phone in the middle of the night. However, it is not pocket sized, and at nearly £40 it is probably a book

to keep under lock and key on the children's ward.

SUSAN LAURENT
Senior registrar

Child Health Matters. Edited by Sally Wyke and Jenny Hewison. (Pp 156; paperback.) Open University Press, 1991. ISBN 0-335-09393-0.

When I went for one of my first interviews for a paediatric job I was asked by one of the interviewers whether it would make any difference to my clinical practice if I were a parent. At the time I said it would (thinking that must be the right thing to say), now I am convinced. It has changed my practice because I have had to look at child health from a different perspective. In many ways this book succeeds in doing the same thing in that it enlightens the reader about a parent's eye view of services and child health in general.

It is a modern, politically up to date book that provides a mixture of social, psychological, medical, and environmental emphases. The contributors come from a wide variety of backgrounds and there is a useful summary of each chapter in the book at the beginning that acts as a useful way of orientating the reader.

Jenny Popay's chapter on 'women, child care and money' raises many issues including health professionals' need to stress the importance of what women living in poverty can do and *not* what they cannot, the concept of relative poverty related to lack of control of financial assets within a family, the role of the extended family in supporting mothers on low income, the need for jobs, access to money and good quality child care, and the need for health care provision for mothers themselves. The same chapter emphasises how a mother's and health professional's concepts of normality often differ and the methodological difficulties of getting mothers to talk about 'minor' problems. There is a constant need to be *seen* to be dealing appropriately and mothers feel very anxious about health professionals' attitudes to them. The importance of reassurance in general is stressed again later in the book in Clark and Hewison's chapter on 'whether or not to consult a GP', and half the sample of parents who were questioned stated that reassurance was the single most important thing that they received from their doctors. This certainly re-enforces my own belief that reassurance must be built in as a valid outcome measure for health services offered to children.

'Social and cultural assumptions have serious consequences when they serve as measures of "normality" in the area of child development'. In the chapter on 'understanding the needs of ethnic minorities' this idea is well explored using the concept of the childhood/adulthood continuum and the differential emphasis placed on the tools (toys) in contrast to the context of play to illustrate different perspectives. We are told about how certain health education exercises have shown an insensitivity to parents needs and knowledge, including the Surma story and misguided health advice given to women wishing to fast during Ramadan. It is obvious there are many conflicting religious, family, and health demands made on women in these groups.

Throughout the book one gets the impression that sociological research methodology may be less rigorous in its nature, but one certainly gets more of the 'feely' stuff that is so important for the new NHS, and yet does not appear to have been so readily accepted by the scientific community as yet. Contrasts between health professionals and parents are brought out in the other chapters on ideologies of child care and an interesting chapter on the use of services by parents of children with cough. This certainly dispels the myth of unnecessary service usage by using the interesting technique of scenario presentation and producing a severity threshold. Later chapters provide extremely useful reviews on breast feeding and asthma. The latter places emphasis on nurse run clinics, the need for adequate time to educate children and adults in the treatment techniques required, and the usefulness of district based asthma working groups. Jenny Kitssinger's chapter on 'child sexual abuse and the trials of motherhood' re-enforces the often neglected perspective of the mother and her own needs after the disclosure. Jacqueline Mok's chapter on 'HIV' gives up to date practical guidelines for monitoring and treatment of HIV infection in children and the concept of the 'family clinic' set up in Edinburgh, which provides a well functioning community, social services, education, and health interface.

Overall, this is an excellent pot-pourri of material that borrows data from many disciplines involved in child health, including sociology, psychology, medicine, and social anthropology. Child health cannot be seen as the province of one discipline only and this book certainly demonstrates how different disciplines can work together to give a fuller picture and, hopefully, influence a group of more empathic doctors.

M E BLAIR
Senior lecturer in child health (community)

Dexamethasone and meningitis—more evidence

For the story so far see *Archivist* 1991;66:137. Now a study done in Costa Rica has been reported by a team including Dr McCracken (Carla M Odio and colleagues, *New England Journal of Medicine* 1991;324:1525–31).

They studied 101 children with bacterial meningitis admitted to the National Children's Hospital in San José of whom 90% were less than 5 years old. Because antibiotic treatment causes a massive release of endotoxin into the cerebrospinal fluid with a consequent surge in the mediators of inflammation (cytokines) the dexamethasone in this trial was given 15 to 20 minutes *before* the first dose of antibiotic (all the patients were treated with cefotaxime). Random assignment resulted in 52 patients receiving dexamethasone and 49 placebo. Eighty two per cent of the placebo group and 75% of the dexamethasone group had *Haemophilus influenzae* meningitis. Lumbar cerebrospinal fluid pressures were measured initially and after either 12 or 24 hours.

The dexamethasone treated children had a significantly quicker rise in glucose in the cerebrospinal fluid and falls in cerebrospinal fluid white cells, protein, tumour necrosis factor α , and platelet activating factor. They also had a significantly greater fall in cerebrospinal fluid pressure and rise in cerebral perfusion pressure at 12 hours.

The clinical condition as assessed by the Glasgow coma scale and the Herson-Todd prognostic score was significantly better at 24 hours in the dexamethasone treated children and prolonged fever was much more common in the placebo group. One child in each group died. Neurological sequelae occurred in 31% of the placebo group and 10% of those given dexamethasone ($p=0.008$). In contrast with previous studies the decrease in hearing loss in the dexamethasone group was not statistically significant (6% *v* 16%, $p=0.18$). Neurological sequelae or hearing loss occurred in 14% in the dexamethasone group and 38% in the placebo group ($p=0.007$, relative risk 3.8, 95% confidence interval 1.3 to 11.5). Ultrasound or computed tomography showed cerebral atrophy, ventricular dilatation, or cerebral infarction in 14% and 29% ($p=0.06$).

I'm convinced. There seems now to be very little room for doubt that dexamethasone is beneficial, at least in *H influenzae* meningitis and there is, as far as I know, no reason to believe that meningitis due to other bacteria reacts differently.

The same issue of the *New England Journal of Medicine* contains an extremely thought provoking debate about the ethics of clinical trials.^{1 2} Modern therapeutics is, of course, to a large extent based on the results of randomised clinical trials and nobody doubts their scientific value. Trials of dexamethasone in meningitis were justified because whether it would prove beneficial or not was truly an open question. Now, I would hesitate to introduce further patients into a dexamethasone/placebo trial. The difficulty arises particularly with severe or fatal illnesses where the patient does not get a second chance if assigned to the wrong group. Patients are entitled to expect that their doctors will offer them the best possible available treatment according to their knowledge *and belief*. Can a doctor ethically offer a treatment which he believes (but does not know) is likely (but not certain) to be inferior? Increasing patient knowledge and demands for truly informed consent are bound to force the issue. Patients, for instance, are unlikely to feel obliged to accept the conventional demand for a 5% level of statistical significance. I think we are in for a very vigorous debate.

ARCHIVIST

1 Hellman S, Hellman DS. Of mice but not men. Problems of the randomized clinical trial. *N Engl J Med* 1991;324:1585–9.

2 Passamani E. Clinical trials—are they ethical? *N Engl J Med* 1991;324:1589–91.