The incidence of renal calcification in preterm infants

Str.—In the report by Short and Cooke, the 21 infants developed renal calcification all had bronchopulmonary dysplasia.1 We agree with Short and Cooke. The detailed records of detailed steroid usage the relationship between steroid use and renal calcification was not explored. Their failure to do so is indeed surprising as nephrocalcinosis may be one of the side effects of the now widespread use of steroids for bronchopulmonary dysplasia.2

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DR SHORT AND COOKE COMMENT:
Thank Dr Blumenthal for his interest in our recent article, and note his comments regarding the use of steroid treatment. The hypercalciuric effects of steroids have been utilised for many years in the treatment of hypercalcaemia in adult patients. We certainly considered the possible effects of treatment in our own patients, and recorded dosage and duration of dexamethasone treatment.

The small number of patients with dexamethasone (two infants with bronchopulmonary dysplasia who developed calcification, and one who did not), however, preclude any useful comment upon the effects of such treatment in our study. In the two patients with renal calcification who received dexamethasone, renal ultrasound scans were normal before treatment with dexamethasone, and the relevance of such treatment in the postnatal period merits further investigation. We do not postulate a direct causal relationship between steroid therapy and calcification. We would agree, however, that the increasing use of steroids provides an additional argument for close evaluation of the renal tract in all preterm infants at risk of renal calcification.

Who pioneered the use of alternative donors (and transplants from a non-related blood donor) in bone marrow transplantation?

STR.—Dr Hows writes her opinion that 'The Seattle group has pioneered the use of partially matched family donor transplants...'. I am grateful to Drs Hughes-Jones, Selwyn, and Riches for their account of the pioneering role of Professor Jack Hobbs and other members of the Westminster Bone Marrow Transplant Team in the use of alternative donors (and transplants from a non-related blood donor) in bone marrow transplantation.


Dr Hows comments:
I am grateful to Drs Hughes-Jones, Selwyn, and Riches for their account of the pioneering role of Professor Jack Hobbs and other members of the Westminster Bone Marrow Transplant Team in the use of alternative donors (and transplants from a non-related blood donor) in bone marrow transplantation.

I tried to write a short 'state of the art'
annotation of this specialised area which might be of practical use to paediatricians with a general interest in haematology. The emphasis is therefore on current concepts of donor selection and recent results.

Regrettably in this type of communication there is no space to address interesting historical perspective such as that provided by the Westminster team. Their experience would certainly take pride of place in a full length review article.

District handicap teams: impediments to progress

Sir,—Of the reasons discussed by Bax and Whitmore for lack of progress in setting up Court type district handicap teams, 1 much the most important is the inability or unwillingness of many doctors to contribute to effective interdisciplinary work. Education and social service departments are reluctant to commit resources to child development centres, especially those on hospital sites, because they anticipate medical domination of operational policy (referrals, etc.), day to day management, and ‘patient care’ decision making. It would take much more than a ‘commitment to provide a peripatetic service in satellite premises’ reservations.

Similarly, professionals employed by education and social services are disinclined to recognise a divine right of doctors to be in charge under all circumstances, and are unlikely to accept this in such an environment. A senior social worker, himself committed to interdisciplinary working, said to me recently, ‘a doctor’s definition of a team is a group of people working together from he/she (the doctor) tells what to do’. The joke is on us, but it is really not at all funny.

Bax and Whitmore think that the Court committee’s concept of a district handicap team would be sound: I agree (I was a member of the committee) in the historical context of the late 1970s. Much has happened since then, however, and the changes in thinking and policy in the Children Act 1989, the Disabled Persons’ Act 1986, and the Children Act 1989 require that responsibilities for the management of childhood disability are shared far beyond the health services terms of reference of the Court committee. Of course the medical and health related contribution continues to be crucial and even pivotal in many instances, especially in early childhood. Unless we collectively are more whole hearted and less professionally arrogant in our attitude to interdisciplinary work, however, our influence will increasingly be marginalised.

We risk being consulted rather than involved, which would jeopardise comprehensive care: the ultimate losers would be the children and their families.

The child development centre is a medical model (for example, in siting and referral procedures), and therefore inappropriate on its own for the 1990s. Bax and Whitmore also acknowledge some of the problems of trying to cater for children of all ages in a single centre. How indeed do you combine suitable decor, furniture, equipment, and comprehensive service provision for infants and toddlers, preschool and school children, and adolescents all under one affordable roof?

I suggest that the way ahead is to develop a suitably updated concept of teams which work flexibly in different contexts and premises, one of which might well be a ‘centre’ on a hospital site where facilities for early medical identification and diagnosis are linked with the initial stages of treatment and ongoing assessment.

Interagency discussions about the Children Act present us now with excellent new opportunities to create or reinforce effective teamwork. Doctors involved in this collaboration need to be sure that they do not take any pedestals with them.

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District handicap teams in England 1983–8

Sir,—We wish to make it clear that in our article on district handicap teams 1 our third recommendation (p664) is that the child development centre should initially be able to cater for the needs of all children under 16 years (not under 10 as stated) and for older children in the absence of adequate similar facilities for disabled adolescents.

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Major problems with paediatric bed usage statistics?

Sir,—MacFaul and Long show that paediatric bed occupancy in two children’s wards in Pinderfields Hospital can be calculated in five different ways, giving results ranging from 73% to 106%, depending on the treatment of empty beds and bed borrowing between specialties.

1 Interesting as the exercise is, Dr MacFaul and Mr Long might ask their district management why such calculations should be necessary. The Körner committee recommended in 1982 that empty beds should no longer be allocated to a specialty. 2 Allocation of beds to specialties should be seen as a statement of operational planning intent and does not have to correspond to beds physically occupied or unoccupied, counted on a daily basis. 3 Because of flexible use of beds between specialties, it is necessary to distinguish between ward bed occupancy and specialty bed occupancy. Ward occupancy is calculated as:

occupied bed days in ward
available bed days in ward

for each ward. This gives, as MacFaul and Long show, 54% for ward A and 69% for ward B in their example. Specialty occupancy is calculated as:

occupied bed days in any ward
allocated bed days for specialty

In the Pinderfields example, on the information given, this is:

949 (ward A) + 3074 (ward B) + 201 (intensive care and other)

5187 (allocated to paediatrics)

giving a paediatric bed occupancy over the period shown of 81%. This method follows not only ‘the spirit of Körner’, but also the letter.

This level of occupancy is well above the optimum of 75% for acute children’s services mentioned in Health Building Note 23 and supports concerns about a possible shortage of capacity to deal with peaks in demand.

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3 Health Services Information Branch. User’s guide to statistics about the clinical activity of departments and services provided on or off a hospital site. London: Department of Health, 1988:173.


Dr MacFaul and Mr Long comment: We thank Mr Glickman for his helpful comments on our paper. It is indeed the case that the Körner committee recommended that it should no longer be required that unoccupied beds be allocated to a specialty. Furthermore, it was recommended that bed occupancy statistics cease to be used as a measure of efficient bed usage (Körner first report para 9.39). 1 However, in Yorkshire Regional Health Authority, bed occupancy measures were reintroduced in response to demand from health authorities: hence the development of the modified SH3 (TSFEB) referred to in our paper. It is a concept with which clinicians are familiar and bed occupancy possibly identifies more readily shortfall of specialty paediatric bed allocation over peak bed usage periods. Hence it was used in this paper. One main point of the paper, however, was to identify the variation in interpretation of Körner recommendations which may occur within a district—thereby limiting the value of between—district indicators. Mr Glickman’s calculation of occupancy disregards, as Körner advised, any allocation of empty beds to a specialty but he does necessarily include the nominal allocation of beds for use by the specialty. Such allocation is also necessary to calculate throughput (throughput is calculated in terms of number of beds that the specialty was intended to use, rather than the beds estimated to be available). For patients with the same length of stay during the study period report in our paper, throughput figures varied considerably (between 23/83 and 34/68) according to the way in which the nominal allocation of beds was made between two wards. The throughput figures based on the calculations used by Mr Glickman are given in option (1) in our paper.

Using the maximum flexibility—our option (5)—the highest throughput and bed occupancy figures were achieved. This maximum flexibility of usage seems more clearly to be in the spirit of Körner. An important point evident from the study was the significance of when, in the 24 hour