We agree that treatment itself is likely to be an important factor in subsequent nutritional progress and in our study the prevalence of malnutrition, identified by arm anthropometry, rose to 46% over a median follow up period of 7.5 months.²

We conclude therefore that malnutrition in children with cancer is more common than generally recognised, particularly so at diagnosis, and that impaired energy intake is a factor in its causation. Further studies such as those by Bond and coworkers are required to explore the suggestion that changes in energy utilisation are also important, either at diagnosis or during treatment. Clinicians however must be aware of the greater incidence of malnutrition in these children and initiate appropriate strategies for nutritional support.⁶

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- 1 Bond SA, Han AM, Wootton SA, Kohler JA. Energy intake and basal metabolic rate during maintenance chemotherapy. *Arch Dis Child* 1992; 67:229-32.
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Rehabilitation and outcome after severe head injury

SIR,—The recent paper by Scott-Jupp *et al* is an important contribution to the subject of rehabilitation of head injured children.¹ It correctly highlights the inadequacy of present services including support and training for teachers who provide long term educational services.

We studied 220 children of whom half were followed up for three years after injury.² We found a substantial cognitive improvement between one and three years, a time when rehabilitation programmes have often ceased. Reporting on cognitive and behavioural problems at six months after severe injury must include many still in the early stages of recovery and before these cognitive gains have occurred.

In our study the relationship between length of coma and outcome is clear. Of 109 patients still comatose on transfer to rehabilitation (median 62 days) 48 remained completely dependent for all activities of daily living, against only one with partial dependency of 111 admitted conscious. The outcome in patients still comatose at three months and six months after injury was also found to be quite different.

Of interest is the fact that 87 (35%) of our children had a history of learning disorder or had shown attention deficit, impulsiveness, or emotional behavioural problems before injury. This would support the authors' impression that many of their children did have pre-existing problems placing them at increased risk for injury.

The data from Scott-Jupp *et al* is interesting,¹ but only a small number of children were followed up for a substantial time and the results must be interpreted with caution.

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- 1 Scott-Jupp R, Marlow N, Seddon N, Rosenbloom L. Rehabilitation and outcome after severe head injury. *Arch Dis Child* 1992; 67:222-6.
- 2 Boyer MG, Edwards P. Outcome 1 to 3 years after severe traumatic brain injury in children and adolescents. *Injury* 1991; 22:315-20.

Paediatrics in the accident and emergency department

SIR,—I read the article by Phillips and Robson with interest.¹ The writers say that the Specialty Advisory Committee requires only three months paediatric experience before accreditation as a consultant. In 1974 when a working party was set up to discuss the training programmes for consultants in charge of emergency departments and the possibility of planning a programme for senior registrars, paediatrics was listed as being 'a minor specialty' and it was with the greatest difficulty that I managed to persuade other members of the working party that it was so important that a specific requirement of time should be included.

I agree that three months is not enough but I can assure you that to achieve even that was a considerable victory.

I have felt for a long time that community paediatricians could play a most useful part in accident and emergency departments where children are seen but which are not part of a children's hospital. Appointments that are linked between the hospitals and the community are valuable at junior levels and can be even more so at senior ones.

A properly run paediatric accident and emergency department can save money for a hospital by reducing the numbers of children who are admitted. This can apply with many types of problems. One example among many, in Sheffield, is that of the about 200 children who are seen each year with acutely painful hips, the majority are dealt with without admission.

Many x ray films, drugs, and unnecessary investigations can be avoided with benefit both to the child and to the finances of the hospital. A lot of problems, medical, surgical and social, can be recognised at an early stage and treated.

More children are brought to accident and emergency departments than to all outpatient departments put together—they deserve a service that is appropriate to their needs and to the needs of their parents.

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- 1 Phillips BM, Robson WJ. Paediatrics in the accident and emergency department. *Arch Dis Child* 1992; 67:560-4.

Intravenous volume replacement: which fluid and why?

SIR,—Lucinda Huskisson has done well in her outline of the continuing debate on which fluid to use during resuscitation.¹ Doctors involved in the resuscitation of major trauma are now increasingly using the methodology of Advanced Trauma Life Support.² This concentrates on the first hour after trauma—the 'golden hour'—and presents a standardised approach to the management of trauma. With regard to fluid replacement, Hartmann's solution and blood are the only two fluids advocated. In the child a regimen of three challenges of 20 ml of Hartmann's solution per kg is advised followed by 10 ml per kg of blood if the patient is still unstable. Continuing instability as judged by cardiac status, conscious level, skin perfusion, and urine output should prompt definitive operative care. Paediatricians who find themselves involved in resuscitation in the accident and emergency department should be aware of this protocol as it serves to keep arguments over crystalloids and colloids out of the resuscitation room—as Dr Huskisson demonstrates by her 57 references that debate takes longer than a golden hour.

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- 1 Huskisson L. Intravenous volume replacement: which fluid and why? *Arch Dis Child* 1992; 67: 649-53.
- 2 American College of Surgeons. *Advanced trauma life support*. Chicago: American College of Surgeons, 1989.

Sister journals

SIR,—David Mellor was undoubtedly right to criticise the English translations of the titles and abstracts of articles published in *Archives Françaises de Pédiatrie*.¹ Some of them were certainly inaccurate and/or clumsy. We have taken his comments to heart and retained a biomedical translator. Let us hope that he will soon have no cause for such comments.

Dr Mellor cannot understand why there are many fewer original articles and clinical reports in *Archives Françaises de Pédiatrie* than in *Archives of Disease in Childhood*. There are two very simple explanations. First, French paediatricians publish their best work in English language, mainly American, journals. Curiously, the dominance of English in the scientific world has led clinicians and researchers wanting to be sure that their work is known to publish in English. This is exacerbated by the tendency of granting bodies in France to give a priority to such publications.

Second, many of the subscribers to *Archives Françaises de Pédiatrie* are more interested in articles on new techniques, analyses, and applications than in research articles. This problem is not peculiar to French paediatrics; several other European journals have the same balance. The survival of our journal depends on the number of subscribers, and more and more of them do not want articles that are too research oriented or that deal with very rare conditions. This may be unfortunate, but it is the case.

The French, in common with other Europeans, probably have less difficulty reading and writing English than the English have in

communicating in another language. We will continue to make an effort to communicate in English, as this provides a wide range of other benefits. The opening of the European common market may well be a good time for European paediatric journals to discuss the possibilities of better communications or even cooperation to avoid the 'arrogance' of one particular group trying to protect its own language. Lastly, Dr Mellor compared the April 1991 issues of the two journals. We do occasionally, perhaps not frequently enough, publish reviews of books that are sent to us.

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1 Mellor D H. Sister journals—France. *Arch Dis Child* 1991;66:1364.

AUTUMN BOOKS

Essential reference

Recently the library committee at our children's hospital made finances available for the purpose of a selection of books, to be housed in a suitably secure setting—books do have a habit of disappearing—yet be available for 24 hour reference to solve the inevitable problems of diagnosis, investigation and management, which seem to occur in the middle of the night. Having democratically sought the opinion of many of the medical staff (senior and junior) it was surprising how uniform were people's opinions on what made an 'essential reference book'; this article summarises these views.

For the junior doctor just starting in paediatrics, the ideal literary purchase is one describing what to do in every emergency situation. Treatments and trends change so quickly in medicine that an up to date reference is essential. Thus, *Paediatric Emergency Medicine* by M Grossman and R A Dieckmann (Lippincott 1991) came out top in this section, out voting *Paediatric Emergencies* (J A Black: Butterworth, 1987) and the still easily read *Paediatric Emergencies* by Tom Lissauer.

Another clearly practical handbook which received a lot of votes and will certainly have a place on our 'instant access' shelf (although many staff already have their own copy) was *A Paediatric Vade-Mecum*, edited by Jack Inley and most recently updated in 1990.

Chemical Pathology and the Sick Child, edited by B A Clayton and J M Round (Blackwell Scientific Publications, 1984) was the outright winner in the 'best book to explain why this child is hyponatraemic, has hyperammonaemia and seems moribund' section. Covering all aspects of chemical pathology from neonatal to pubertal problems, while it is not 'light reading' it is a very useful guide on when to investigate, how to investigate, and what the results mean. It allows you to sound as if you know why you are asking the poor 'on call' pathologist for yet another lactate concen-

tration and might even stop you asking for one!

For a basic paediatric textbook, more for the quiet moments in the mess, when there is little else to do, the consensus of opinion (shared by previous contributors to this section) was for *Nelson Textbook of Pediatrics* (14th Ed, Saunders, 1991) in preference to the other standard works *Textbook of Paediatrics* (J Forfar and G C Arneil) or *Principles and Practice of Paediatrics* (F A Oski et al). As a reference to check whether the child in 'admissions' might really have Loeffler's syndrome (Nelson, page 909), it is undoubtedly very adequate, and earns its place in our emergency collection. However, even though it was more popular with junior staff than its British equivalents, for the premembership readers, I cannot help but worry that some of its transatlantic views might not be warmly greeted by the examiners of the Royal Colleges.

Having confronted the emergency, made a diagnosis, checked the chemical pathology, and organised the basis resuscitation, the next difficulty in management is deciding drug dosages when the pharmacy is closed. In the prescribing category, the most popular choice was undoubtedly the *Paediatric Formulary* (2nd Ed, 1990), produced by Lewisham and North Southwark Health Authority (Guy's Hospital to you and me), not as easy to carry in one's handbag/back pocket as the *Alder Hey Books of Paediatric Prescribing*, but generally felt to offer that little bit more.

At present we feel the books described will allow us to 'double check' most clinical conundrums and form the basis of our 'out of hours' emergency library. We are a children's hospital, but are frequently confronted with sick neonates, thus undoubtedly soon our collection will need to include a neonatal guide—here N R C Robertson's *Manual of Neonatal Intensive Care* is still very popular, but a *Handbook of Neonatal Intensive Care* (H L Halliday, G B McClure, and M Reid, 1989) and *A Neonatal Vade-Mecum* (P J Fleming, B D Speidel, and P M Dunn) are both compatible. Other suggestions for our 'emergency' library that received more than one vote and seem sensible, but financial restraints do not allow their purchase at present, include *Practical Genetic Counselling* by P S Harper (Butterworth, 1988), a very useful book to have on the ward or in the special care unit, answering many of the simpler counselling questions asked by parents, in addition to a malformation book. Here, *The Malformed Infant and Child* by R M Goodman and R J Gorlin (Oxford University Press), with its simple line drawings, was as popular as the well established *Smith's Recognisable Patterns of Human Malformation*. A dermatology book is very useful for any children's ward with a receiving room and essential for an accident and emergency department. *Essential Paediatric Dermatology* by J Verbov (Clinical Press Ltd, 1988) offers good quality colour illustrations for comparison and is easily read. *The Handbooks of Investigation in Children* series were reasonably popular—designed to tell you whom and how to investigate and what the results mean. This series now covers haematology, endocrinology, neurology, and renal medicine. Useful for day case investigations, we felt the previously mentioned *Chemical Pathology and the Sick Child* would suffice for our emergency shelf.

These views signify only the ideas of myself and colleagues in my hospital and as such are obviously not sacrosanct. However, I feel confident our 'emergency reference' books will be regularly consulted and hopefully will

answer most of the diagnostic difficulties confronting us when the main library is closed.

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10. Recent Advances in Paediatrics. Edited by T J David. (Pp 246; £22.50 paperback.) Churchill Livingstone, 1992. ISBN 0-443-04520-8.

'I have some news for you which you were not expecting'. This statement, taken out of context from a perceptive chapter on the management of Down's syndrome summarises a valuable extension to a well known series.

There are new insights into old favourites, Crohn's disease, the *bête noir* of district paediatrics; the management of severe asthma—timely when many departments are subjecting their procedures to audit, and hypoglycaemia where we are invited to banish the diagnosis of asymptomatic hypoglycaemia. There is good advice on investigation but for the older child a firm statement on what constitutes the blood glucose concentration below which the tests should be performed would have been useful.

There are useful chapters on what for most of us are rare diseases, namely HIV infection and genetic disorders appropriate for bone marrow transplantation. Although some such disorders could present on a ward round tomorrow. The 'new genetics' is already having its effects on our practice and increasing knowledge of neonatal oxygen radical disease is set to change our neonatal protocols in the next five years.

There is purple prose telling the story of 'outlandish factitious disease'—another 'new' disorder. Do some of our most brittle diabetic youngsters fall into this category?

This book is written for the general paediatrician. It succeeds—every chapter is relevant. It variously criticises our practice, invites us to drop outdated concepts, updates flagging knowledge of the scientific basis of some diseases, and supports us against modern myths—as in the chapter on food additives.

It is hard to criticise. One assumes that there is a publisher's limit on size and hence content should be viewed in the context of current issues of importance and recent editions in the series. However, with the increasing dissolution of traditional boundaries between hospital and community there should be a place in each volume for primary and community child health topics. All chapters would benefit from the discipline of 'Key points for clinical practice' and 'Key questions for the future' would be thought provoking. Some of the physiology is a little hard going as in the description of oxygen free radicals and would have gained from further expansion.

However, these are small points in the context of a book which is a very valuable aid to our clinical practice and maintains the high quality established by its predecessors.

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The Fetal and Neonatal Brain Stem—Developmental and Clinical Issues. Edited by M A Hanson. (Pp 289; £50 hardback.) Cambridge University Press, 1991. ISBN 0-521-38357-9.

The immature brain stem appears to have the major role in control of fetal breathing and its circulation, modulation of pain response, and