under normal circumstances be recorded by our local coroner’s office. In our efforts to resolve the difficulty, we encountered a more complete but less detailed source of data. In those districts where child health surveillance and school health records are computerised, a comprehensive list is kept of children who have died in order that grieving parents are not inadvertently sent invitations to attend child health surveillance appointments. The list is usually complete and includes local residents who have died outside of the district boundaries. The information contained in these lists usually just extends to the child’s name, address, and cause of death with no further details. However, we found these records of use in supplementing data supplied by the coroner’s records.

We would concur with Dr Levene in her plea for a comprehensive prospectively compiled childhood accident mortality database. Coroners’ inquisitions and child health records will yield basic data which might, perhaps, be usefully supplemented by confidential inquiries into the circumstances of individual accidents. Collation of locally relevant data is a key element in child accident prevention which should be a priority for every health authority.

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Dr Rushforth and colleagues comment:
We note Dr Jones’ suggestion of a possible route of a percutaneous central venous catheter, via diploic veins, to lie in the middle meningeal vein to explain a subdural collection. However, the diploic veins are absent at birth and do not develop until around 2 years of age.1 The infant in the case report was still less than 37 weeks’ corrected gestational age at the time of the incident.2

It may be possible to suggest passage of a catheter via an emissary vein to lie in the sigmoid sinus. However, this route is tortuous and would not be supported by the appearance on the original radiograph.

We agree that if a catheter will not advance, it is probably lodged in a small vein and should be withdrawn. Blood flow of blood back through the catheter would support its tip being in a large vein, as in the case in our report.2 However, the ideal position for central venous catheters should be the right atrium where risk of retrograde flow is less.


Rushforth et al.

Health for all children

Str.—The importance of early diagnosis of biliary atresia has been stressed repeatedly by hepatologists and is now acknowledged by those responsible for child health surveillance programmes.1 However, it does seem premature to suggest that we should change the age at which the infant’s first formal postnatal review is performed,2 particularly as the revised programme of child health surveillance recommends that this review should be combined with the first immunisation at the age of 8 weeks.3

Each district in the UK will produce one new case of biliary atresia every four or five years. We need to know what strategies would be best to achieve early detection of such a rare condition. Formal screening may be less effective than professional education combined with easy rapid access to the appropriate tests and the expertise to interpret them. The paediatric hepatology team at King’s College Hospital is uniquely well placed to determine what work load would result, and what unforeseen problems might arise, if the various strategies proposed were to be implemented. Our experience with neonatal screening for hearing loss has taught us how much effort and commitment are required to make such programmes work effectively, even when run by an enthusiast.

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Familial asplenia

Str.—We read the article on haemophilus septicaemia in congenital asplenia1 and the subsequent correspondence2 with great interest. We would like to describe our experience, which illustrates the importance of familial asplenia and also a potential disadvantage of not performing a necropsy.

A 21 month old girl, the second child of non-consanguineous white Australian parents, presented to a peripheral district hospital with a short history of fever and delirium. She was profoundly shocked with widespread purpura and ecchymoses. A presumptive diagnosis of meningococcaemia was made, resuscitation with artificial ventilation, antibiotics and plasma was commenced, and transfer to this hospital was requested. On arrival here she was moribund and died within minutes. Blood cultures were sterile. Necropsy was requested but declined by the distraught parents.

The parents subsequently had a third child, a boy, who presented at the age of 4 months with a rapid onset of shock and purpura. He was found to have purpura fulminans, with confluent ecchymoses of his distal limbs, ears and nose, and with purpura on his lips. Cultures of blood and cerebral spinal fluid grew Streptococcus pneumoniae. Blood films showed numerous erythrocytes containing Howell-Jolly bodies. An ultrasound scan revealed no spleen and asplenia was confirmed by tomoscopy. In the deceased child, asplenia was normal. His sister’s original blood film was retrieved from the peripheral hospital and the red cells were also found to contain many Howell-Jolly bodies. The oldest child is well, has a normal peripheral blood film, and has a spleen on ultrasound.

The patient required intensive resuscitation with artificial ventilation, colloid, and