inotropes. He developed peripheral gangrene, requiring amputation of the fingers but not thumb of his left hand to the metacarpophalangeal joints, amputation of his right fifth finger to the proximal interphalangeal joints, amputation of all his toes, and removal of necrotic tissue and bone on his left heel. He had extensive skin grafting to the lower limbs. Good function of his right hand was predicted. He was discharged on prophylactic antibiotics. Polyclonal pneumococcal vaccine and meningococcal vaccine will be given at 24 months and conjugate vaccine against _Haemophilus influenzae_ type b as soon as it is available in Australia.

These siblings presumably have reproductively inherited congenital asplenia and normal hearts. Hereditary splenic hypoplasia was first described in three of five siblings by Kevy et al.\(^1\) In a review of 60 children with asplenia or polysplenia from Toronto, there were two families in which two siblings had isolated asplenia and one family in which two siblings had polysplenia.\(^2\)

It was assumed that our first patient died of meningococcal sepsis although in retrospect she may have had pneumococcal sepsis, as both organisms may sometimes fail to grow from severe cases. In an ideal world, a necropsy would have been performed, would have revealed asplenia and we would have screened the next child at birth. Prophylactic antibiotics have been shown to be effective in reducing the incidence of bacterial sepsis in children with congenital asplenia,\(^3\) and immunisations as already described could have been given at the appropriate age.

**Growth performance of affluent Indian children under 5 years of age**

Str,—Paediatricians interested in the growth patterns of children of families originating from the Indian subcontinent may like to know of a study by the Nutrition Foundation of India on ‘growth performance of affluent Indian children (under five)’.\(^4\) The study was undertaken to determine whether the international growth standards developed by the National Center for Health Statistics in the USA were applicable to Indian children. A corollary to this was the desirability, or otherwise, of collecting data on Indian children on a national scale.

The authors accepted that socioeconomic and environmental factors and the malnutrition-infection complex rather than genetic factors were the main constraints determining the differences between the growth performance of children in developed and developing countries.\(^5\) In order to eliminate these factors as far as possible, only children from affluent families (they took some pains to define ‘affluent’ were studied in seven cities: two in the north (Ludhiana and Delhi), two in central India (Kota and Varanasi), one on the west coast (Bombay), one in the southern India (Bengaluru) and one on the east coast (Calcutta).

The results showed that ‘affluent’ children (0–5 years) in Ludhiana and Delhi in the north had attained a level of growth in height and weight which nearly corresponded to those of the international growth standards and it was therefore concluded that these standards could be used for Indian children. In the remaining cities where growth fell below the American standards it was thought that the explanation lay in the dietary differences between the various parts of India.

The value of this study is that paediatricians in Britain can use (or continue to use) the American or the Tanner-Whitehouse standards for the children of Indian origin in the important 0–5 year period. It must be emphasised, however, that these standards do not apply to the neighbouring countries of Pakistan, Bangladesh, Nepal, and Sri Lanka. Those interested in the details of the study should consult the original report.

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**BIRTHWEIGHT RATIO IN PUBLIC HEALTH**

Str.—A similar birthweight ratio to that used for guidance in sophisticated neonatal intensive care discussed by Dr Lucas et al.\(^6\) has been suggested as a public health indicator. This was termed the ‘socioeconomic birthweight [lb wt] quotient’ (or ratio).\(^7\) It was defined as:

\[
\text{average birth wt low socioeconomic population} \times 1000 \\
\text{average birth wt upper socioeconomic population}
\]

It was considered as a rough potential cumulative measure of ‘social development’, especially of prenatal care, maternal nutrition, and infections (notably placental malaria)\(^8\).

This approach is only valid when the community concerned is, in general, genetically uniform. Also, as always with such comparisons, problems occur in defining the two groups. Generally well nourished, genetically homogeneous communities with good prenatal services, as in Denmark, should have an index of 1000. In a study in an area in India, results ranged from 872 to 885.\(^9\)

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