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 third 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. Polyvalent 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 reccessively inherited congenital asplenia and normal hearts. Hereditary splenic hypoplasia was first described in three of five siblings by Kevy et al. 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. It was assumed that in our first patient died of meningococcal septicaemia 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, and immunisations as already described could have been given at the appropriate age.

There are two important medical aspects to be considered when planning care for Indian children. The first is 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 Indian children in developing and developed countries. 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 south (Bangalore), 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.

BIRTHWEIGHT RATIO IN PUBLIC HEALTH

SIR,—A similar birthweight ratio to that used for guidance in sophisticated neonatal intensive care discussed by Dr Lucas et al. has been suggested as a public health indicator. This was termed the 'socioeconomic birth weight [wt] quotient' (or ratio). It was defined as:

\[
\text{average b wt} \text{ low socioeconomic population} < 1000 \\
\text{average b wt} \text{ upper socioeconomic population}
\]

It was considered as a rough potential cumulative measure of 'social development', especially of prenatal care, maternal nutrition, and infections (notably placental malaria). 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. It was concluded that a birthweight ratio of less than 900 was associated with increased perinatal mortality and morbidity. Babies with birthweight ratios of less than 900 had a higher mortality and lower growth rates in the first year of life than those with higher ratios.

Growth performance of affluent Indian children under 5 years of age

SIR,—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 fives). 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 developing and developed countries. 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 south (Bangalore), 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.

BIRTHWEIGHT RATIO IN PUBLIC HEALTH

SIR,—A similar birthweight ratio to that used for guidance in sophisticated neonatal intensive care discussed by Dr Lucas et al. has been suggested as a public health indicator. This was termed the 'socioeconomic birth weight [wt] quotient' (or ratio). It was defined as:

\[
\text{average b wt} \text{ low socioeconomic population} < 1000 \\
\text{average b wt} \text{ upper socioeconomic population}
\]

It was considered as a rough potential cumulative measure of 'social development', especially of prenatal care, maternal nutrition, and infections (notably placental malaria). 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. It was concluded that a birthweight ratio of less than 900 was associated with increased perinatal mortality and morbidity. Babies with birthweight ratios of less than 900 had a higher mortality and lower growth rates in the first year of life than those with higher ratios.

Growth performance of affluent Indian children under 5 years of age

SIR,—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 fives). 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 developing and developed countries. 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 south (Bangalore), 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.

BIRTHWEIGHT RATIO IN PUBLIC HEALTH

SIR,—A similar birthweight ratio to that used for guidance in sophisticated neonatal intensive care discussed by Dr Lucas et al. has been suggested as a public health indicator. This was termed the 'socioeconomic birth weight [wt] quotient' (or ratio). It was defined as:

\[
\text{average b wt} \text{ low socioeconomic population} < 1000 \\
\text{average b wt} \text{ upper socioeconomic population}
\]

It was considered as a rough potential cumulative measure of 'social development', especially of prenatal care, maternal nutrition, and infections (notably placental malaria). 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. It was concluded that a birthweight ratio of less than 900 was associated with increased perinatal mortality and morbidity. Babies with birthweight ratios of less than 900 had a higher mortality and lower growth rates in the first year of life than those with higher ratios.
tracheal aspirate was sensitive to penicillin, erythromycin, and cefotaxime.

Despite aggressive intensive care and adequate antistreptococcal antibiotic treatment, toxin release may occur late in the illness and have a fatal outcome.

J EASON
W LENNEY
Royal Alexandra Hospital,
for Sick Children,
Duke Road,
Brighton BN1 3YN

I LEWIS
Crawley Hospital,
West Green Drive,
Crawley,
West Sussex RH11 7DH

Gastrointestinal complications associated with dexamethasone treatment

SIR,—While the recent reports of gastrointestinal complications in preterm babies receiving dexamethasone for bronchopulmonary dysplasia emphasise the need to observe these babies with ever greater vigilance,1 2 it is worrying to note that perforations can also occur ‘silently’ and escape clinical recognition. Unlike most of the babies described in these reports who rapidly became unwell and required vigorous resuscitation, we recently had a case who developed duodenal perforation eight days after dexamethasone treatment for chronic ventilatory dependency and yet the abdominal signs evolved insidiously over two days with remarkably little respiratory, haemodynamic, or metabolic embarrassment to the baby and the presence of free air in the peritoneum was detected only after a routine radiograph.

It is possible that this baby tolerated the perforation better because she was being ventilated, albeit with low rates and inspiratory pressure, and was therefore better able to cope with the splinting of the diaphragm by the pneumoperitoneum. At the same time, it is also possible that dexamethasone modified the abdominal signs, as has been described in adults.4 These observations merit attention especially as a number of studies devoted to look into the efficacy of dexamethasone in neonatal respiratory distress syndrome are already on the horizon. We also feel that while the temporal relationship of dexamethasone treatment in the above cases was more than coincidental, there are many other factors present in this subset of population known to predispose to gut ischaemia and perforations, which should be included in the analysis while calculating the benefit:risk ratio of steroid treatment.

HEATHER SMITH
SUNIL SINHA
Neonatal Unit,
South Cleveland Hospital,
Manton Road,
Middlesbrough,
Cleveland TS4 3HW

Misuse of the English language

SIR,—I have just perused your September issue, and with tongue only slightly in cheek, write to enlist your help in a campaign similar to our joint efforts to stamp out duplicate publication. I refer to the defence of our language, which we colonials inherited from you several centuries ago.

Although I really appreciated the papers on heart-lung transplantation, which seem to have been written more honestly than most articles on transplantation on this side of the Atlantic, I was distressed to note that every writer referred to the ‘transplanted children’, rather than ‘the children with transplants’. As I am fond of saying, organs, not children, are transplanted. This error is being perpetuated in many journals; I hope that you will help us correct it.

My second concern has to do with the misuse of the word ‘regime’ when ‘regimen’ is intended. I found this at least twice in your September issue.

I often comment to our junior faculty members that the British are to be admired for their succinct style in writing for medical journals. Thus, I hope that you will join us as we stand, like Horatio, fighting overwhelming odds in the defence of our difficult language.

JOSEPH M GARFUNKEL
Journal of Pediatrics,
CB No 7230, Medical School Wing C,
University of North Carolina,
Chapel Hill, NC 27599-7230, USA

The technical editor comments:
Point(s) taken!

Sister journals

SIR,—In some quarters it will be seen as worthy of a good giggle, in others disingenuous of David Mellor to confess that his school French ‘has not really been kept fresh . . . from occasional holidays in French gites . . . and at the same time to complain of examples of poor translations (into English) of titles and summaries in Archives Françaises de Pédiatrie;4 and then to continue with ‘Clearly (that journal’s) parochiality must be largely to do with the difficulty non-Francophones have writing in that language’. As a fervent francophile and part time resident in France, the parochiality does seem to be on the other foot when he suggests that all the other ‘European medical journals should be encouraged to become fully bilingual (that is, national language plus English)! (my italics and exclamation mark).

He is right to say that highly skilled medical translators will be in great demand, as non-medicallinguists are notoriously unreliable in the language of doctors. As one who has a vested interest in recreating the entente cordiale, however, and who sympathises with the widespread French resentment at British arrogance in insisting on our own language, I do hope colleagues will become more sensitive in their Archival writings by 1992!

Did Dr Mellor notice the full page advertisement for the Organ der Deutschen Gesellschaft für Kinderheilkunde, entirely in German, on the page immediately after his piece? Gott in . . . !

JOHN DOBBING
University of Manchester,
Department of Child Health,
The Medical School,
Stopford Building,
Oxford Road, Manchester M13 9PT

Dr Mellor comments:
La plumé du professeur est plus puissante que l’épee.