

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.

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- 1 Cone LA, Woodward DR, Schlievert PM, Tomory GS. Clinical and bacteriologic observations of a toxic shock-like syndrome due to *Streptococcus pyogenes*. *N Engl J Med* 1987; 317:146-9.
- 2 Sanderson P. Do streptococci cause toxic shock? *BMJ* 1990;301:1006-7.
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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.^{3 4} These observations merit attention especially as a number of studies designed 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 with 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.

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- 1 Ng PC, Brownlee KG, Dear PRF. Gastro-duodenal perforation in preterm babies treated with dexamethasone for bronchopulmonary dysplasia. *Arch Dis Child* 1991;66:1164-6.
- 2 O'Neil EA, Chwals WJ, O'Shea MD, et al. Dexamethasone treatment during ventilatory dependency: possible life threatening gastrointestinal complications. *Arch Dis Child* 1992;67:10-1.
- 3 Dayton MT, Kleckner SC, Brown DK. Peptic ulcer perforation associated with steroid use. *Arch Surg* 1987;122:376-80.
- 4 ReMine SG, McIlrath DC. Bowel perforation in steroid treated patients. *Ann Surg* 1980;192: 581-6.

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.

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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*,¹ 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-medical linguists 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 . . .!*

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

Dr Mellor comments:

La plume du professeur est plus puissante que l'épée.

The geneticist's dilemma

What should be the aims of clinical genetics? To promote the welfare of those with genetic disease? To offer genetic counselling? To offer prenatal diagnosis and selective termination of pregnancy? To prevent genetic disease? It might be thought that each of these aims would be laudable in certain circumstances but there is perceived to be a dilemma in so far as the first and third of these aims might be thought, on occasions, to be antagonistic. The problem is discussed in a recent paper in the *Lancet* (Angus Clarke, 1991;338:998–1001).

Can a doctor truly respect people who have a genetic disease and at the same time offer termination of pregnancy when that disease is diagnosed antenatally? In some cases I believe he/she can and so does Dr Clarke. He gives as examples severe mental retardation such that the person is socially unaware, and severe and progressive disorders such as Duchenne muscular dystrophy. He is concerned, though, that the extension of therapeutic abortion to less severe disorders such as neurofibromatosis or Turner's syndrome automatically implies that such people are devalued in the eyes of society. It seems at first sight an absurdity for the same doctor to *care* (in both senses of the word) for such people and yet to work to prevent others like them being born. But is it really absurd? Did the introduction of polio vaccine *devalue* people paralysed by poliomyelitis? I don't believe that many people would suggest so. Is there any real difference *in logic* between 'We are going to immunise babies to prevent people being like you' and 'We are going to terminate pregnancies to prevent people being like you'? The only difference, it seems to me, is the difference between immunisation and therapeutic abortion and the issue of the sanctity of life of the fetus. It is not absurd to say, 'You have a problem. I like and respect you but I think that other people would prefer not to have the problem'. If that is accepted, and Dr Clarke does accept it in the case of severe genetic disease, then the issue becomes not the desirability of prevention but the acceptability of the means. Most people, wherever they stand on the 'sanctity of life' issue, feel unease, great or small, about termination of pregnancy and would not accept its use for relatively minor conditions, and, as Dr Clarke points out, the psychological repercussions of termination may cause greater anguish than the disease under consideration. So the means must be balanced against the aims. The prevention of any condition that causes distress is a laudable aim but the means may be unacceptable. Termination of pregnancy to prevent dental caries would have few proponents but those who oppose fluoridation of water supplies do so not because they consider the prevention of caries to be an improper aim but because they object to the 'contamination' of the water supply as the means.

Dr Clarke's second point is to question the validity of 'non-directive' genetic counselling as regards antenatal diagnosis and termination of pregnancy. It is currently part of the philosophy of clinical genetics that the geneticist gives the facts and the 'clients' make the decisions. Can that be true? Doesn't the offer of prenatal diagnosis and termination imply that the geneticist is prepared to accept that termination is morally justifiable for the condition in question? The geneticist can no more act in a moral vacuum than anybody else. There may be a need to reassess the work of clinical geneticists, with more involvement in the care of people with genetic disease, an acceptance that antenatal diagnosis is always directive to a greater or lesser extent, and some attempt to reach a consensus about which conditions justify termination of pregnancy and which do not.

ARCHIVIST