phosphatase being a chance finding. However when we reviewed the cases reported in the medical literature between 40-60% did actually have symptoms of failure to thrive or gastrointestinal disturbance. 1-4 This therefore appears to be a common clinical association.

In all our cases radiology and other liver function tests were normal. Isoenzymes were measured in six cases and all but one showed either a mixture of liver and bone activity or bands between the two, typical of THI. There was a tendency for our cases to cluster during the first three months and this has been previously documented. 4 Although the aetiology of THI remains unclear it may be the end result of different insults (infective or otherwise) in different children; rotavirus was found in one of our cases and adenovirus in another. The importance of the diagnosis currently is its recognition, and in the avoidance of extensive investigations. Other diseases associated with such raised alkaline phosphatase would have clinical correlates such as deranged liver function tests, or abnormal wrist or hand radiographs. A family history of familial study would detect the rare familial type of raised alkaline phosphatase. 4 We suggest the isolated finding of a massively raised alkaline phosphatase in an infant is assumed to be THI unless clinical circumstances suggest otherwise. Isoenzyme analysis and other investigations of bone and liver function were undertaken after eight weeks if the alkaline phosphatase has not begun to fall. Finally as between a half and three quarters of cases present with the related symptoms of diarrhoea, malabsorption or failure to thrive, we suggest that THI should no longer be considered as a pure biochemical phenomenon but rather a condition that does appear to have definite clinical associations.

**Epilepsy in children and the risk of drowning**

**Editor,**—Drs Kemp and Sibert raised the issue of death by drowning in children with epilepsy. 1

We recently had a patient aged 10 years who had had epilepsy for four years and who was on treatment with sodium valproate. He had initially presented with frequent absences and these lasted only for a few seconds at a time. He had no other neurological problems. Before his death he had had no fits for the previous three weeks and had never had any generalised tonic-clonic seizures. He was found by his parents drowned in his bath having been in the bath for 5–10 minute period; he was resuscitated and was admitted to this hospital to the intensive care unit. On admission he was comatose, his pupils were fixed and dilated. He was treated by intermittent positive pressure ventilation, fluid restriction, and anticonvulsants. He developed further seizures the next morning, associated with hyperthermia and hypertension, and died 14 hours after the initial drowning episode. Postmortem examination showed presence of cerebral oedema and a few anoxic changes within his brain.

His history is a little similar to subject 1 in Kemp and Sibert’s paper, that is, a child with normal intellect and no neurological signs who had had only a fairly minor form of epilepsy and no major motor problems. His death underlines the importance of supervision in the situation where drowning is a potential problem. All these cases support the view that all parents who have children, even if they have minor seizures, must either arrange for supervision of their children while they are in the bath or as suggested by Kemp and Sibert use a shower in an unlocked room.

**Dual marker one day pancreatealry test**

**Editor,**—Dr Green and colleagues present interesting data relating to a novel ‘tubless’ test of pancreatic exocrine function. 1 Assayed in this way it will simplify the investigation of pancreatic exocrine dysfunction in childhood seems as difficult to swallow as 200 ml of mannitol solution and 500 ml of clear fluid. Nor do the controls were children and those patients with cystic fibrosis ranged up to 25 years of age. For various reasons some tests which perform well in adults turn out to be less useful in young children. 2 As paediatricians, it is likely to be the infant with diarrhoea and failure to thrive whom we wish to investigate. As pancreatic insufficiency is relatively rare compared with other causes of this presentation, an investigation with high specificity is essential. As the authors have yet to produce any data on this crucial aspect of their test, may I recommend a simple, cheap, sensitive, specific, and repeatable alternative for paediatric patients to be found, if generally only too happy to provide specimens — faecal chymotrypsin measurement. 3 The dual marker pancreatealry test is promising but needs further evaluation; I hope it has not been patented prematurely.

**Pressure reduction of intussusception**

**Editor,**—In this January’s issue of the journal you published a paper from this centre...