temperature. We suggest that mode of feeding be added to the list of factors being investigated with regard to increased heat production.

Differences between breast fed and formula fed infants in metabolic rate, which is directly related to heat production, have already been reported, and we have recently found that the metabolic rate be significantly higher in formula fed compared with breast fed infants at age 12 weeks. Furthermore, total daily energy expenditure (TDEE) measured by isotopic methods has also been shown to be significantly greater in formula fed than breast fed infants. In a longitudinal study in the first year of life, TDEE was found to be significantly greater in formula fed infants at 6, 9, 12, and 15 weeks but to be similar between the diet groups at 6 months and 9 months (P S W Davies, unpublished data). This pattern correlates with the reported distribution of SIDS by age. A number of studies of SIDS have reported higher rates of formula feeding in cases compared with controls. Because SIDS does occur in breast fed infants, formula feeding has not been considered a major risk factor. Some authors have suggested that the relationship between formula feeding and SIDS incidence is an artefact of the relationship between SIDS and social class. However, it is more likely that the reverse is true, and that variables such as family size, social class, maternal age and interpregnancy gap are related to SIDS incidence because of their effect on aspects of infant care, of which formula feeding might be one.

If this hypothesis is correct, one explanation might be that the amount of energy in contemporary formulas is high in comparison to the mean energy content of breast milk. This view has been increasingly supported from recent studies of nutrition, growth, morbidity, and development of breast fed and formula fed infants. These findings support the need for a thorough review of energy requirements in infancy and especially the adequacy of the energy density of infant formulas.

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The physician's hands and early detection of neuroblastoma

EDITOR—The data from some developed countries show that within the past 25 years, the five year survival rates in neuroblastoma have increased twofold from the initial 25%. The outlook for patients presenting over 1 year of age with stage IV remains dismal (20% five year survival). The drop in mortality rates is related to more frequent detection of the tumour before their disease is advanced as well as more frequent incidental detection of the neoplasm (see also Carlsten for further references).

In the years 1943-80 in Denmark, the percentage of incidentally detected neuroblastoma increased from zero to 14%. Among children with incidentally detected neuroblastoma, stages I and II predominated (16% stage I and 20% stage II). Tumours treated for neuroblastoma were 250, and nearly one half of all 53 long term survivors were found incidentally or had ‘spontaneously regress’ tumours. In Germany, and replicating these findings, in childhood, 1 in 60 children, especially below 1 year of age, during obligatory routine check up visits to which almost 90% of patients faithfully report, allowed the incidental detection of neuroblastoma in every sixth patient with this tumour. Out of 65 children at stage I and 60 patients at stage II, incidental detection of neuroblastoma occurred, respectively, in almost every second and third patient with this disease. This may suggest that a systematic approach, a greater awareness of the relatively high incidence of this tumour (the most common solid tumour in children), and the need for good abdominal examination may increase the detection of children with neuroblastoma before the onset of symptoms. The shift to diagnosis at earlier ages and stages may result from more frequent chest radiographs and use of ultrasound. In a recent report, Sawada et al found that even a small abdominal tumour of neuroblastoma can be detected by careful examination. Out of 293 infants suspected of neuroblastoma on the basis of urinary screening, physical examinations revealed a tumour in more than one half of the patients. A careful abdominal examination is of a great importance in neuroblastoma (the primary tumour is in 75-95% of the cases located within the abdomen).

The hands and eyes of a physician have always been and continue to be the most important tools in detecting diseases. A physician may notice slight, rare symptoms of low stages, such as early signs of neuroblastoma, such as Homer's syndrome and associated heterochromia, the watery diarhoea syndrome and the dancing eyes and dancing feet. Never in his entire life is a human being subjected to medical examinations as often as in early childhood. This is dictated by obligatory periodic check ups, physical examinations before vaccinations, and a mother's loving care, prompting her to seek medical assistance any time she sees a sign or symptom which makes her anxious. The skilful hands of a pediatrician, examining the abdomen on these occasions, can contribute to early detection of the low stages of neuroblastoma and to the decrease of mortality rates in this tumour. It is possible to perform this type of screening throughout the world.


SPRING BOOKS


At last – a book about my craft which I can identify with and recommend to trainees and others who may be wondering what we actually do. For me this book fills a gap, amplifying those textbooks that have focused more on the children, by describing the various conditions and treatments which we deal with as child and adolescent psychiatrists. The aim of this book is to help paediatricians and other doctors address the psychiatric aspects of children’s health problems. The editor, Professor Elena Garralda, adds that she hopes this book will be of interest to not only doctors but also teachers, social workers, and to our own psychiatric trainees. She also hopes that the book will help the referral of disturbed children to specialist services. The contributions have all been reprinted from the series in the Archives entitled ‘Types of Psychiatric Treatment’, and which ran for 14 months.

The first two contributions deal with the identification of psychiatric disorders in children followed by a brief overview of the types of available psychiatric treatment, as well as the all important question of efficacy. The remainder of the book then amplifies the types of treatment and management approaches which we use. I cannot pick out one or two chapters for special mention, which is an indication of the high level of each of the
contributions. The topics covered range from individual therapies, family and group therapy as well as pharmacological approaches and a review of inpatient treatments.

There is a group of chapters dealing with the all important consultative and liaison work, parenting breakdown and the subsequent problems, treatment of delinquency, how we organise treatment services, and a comprehensive review of preventive approaches within child psychiatry. As befits a series of articles that were published in the Archives the accent is on the liaison between ourselves and hospital and community paediatrics. The only omission is perhaps behavioural and cognitive behavioural approaches which are undertaken with the child directly, as psychological interventions through parents which are well covered in the book.

I will recommend this book to the groups for whom it is aimed, but I am sure that its appeal will be wider, as it forms such a helpful anputch on child abuse and disorders which will be useful to busy practitioners of child and adolescent psychiatry itself. Definitely one for your individual shelf and not just the library.

David P H Jones
Consultant child and family psychiatrist


It is customary for trainees in general psychiatry to have an opportunity to work in child psychiatry as part of their training. However, child and adolescent psychiatry practice varies considerably from adult psychiatry. This book has been selected as part of a series of Royal College of Psychiatry seminars intended to help junior doctors during their training years. It is a multiauthored book by experienced child and adolescent psychiatrists. It provides a comprehensive and practical introduction into the subject of child and adolescent psychiatry. It follows a standard textbook approach but most chapters are short and easy to read. Chapters include the history of child psychiatry, normal and abnormal development, problems, and developmental delays that are of relevance to child psychiatric practice, and aetiological factors. There are detailed descriptions of classification systems in child psychiatry and of individual clinical syndromes divided according to the developmental stages at which they are most troublesome or apparent. There are sections describing the various treatment modes in child psychiatry as well as specific chapters on child abuse and disorders of parenting, forensic child and adolescent psychiatry, liaison work, and on continuities between child and adult problems.

The book is probably of more relevance to a psychiatrist than a paediatrician and the reader there is limited coverage of the problems most commonly encountered at the paediatric clinic. It should, however, be useful as an introduction to the subject of child and adolescent psychiatry for trainees in psychiatry.

M E Garbala
Professor of child and adolescent psychiatry


Thomas Huxley once remarked that the greatest tragedy of science was the slaying of beautiful hypotheses by ugly facts. The research into cystic fibrosis is a classic example but at long last there is real hope that the pool of knowledge derived from molecular studies with the delta F508 and other cystic fibrosis associated mutants will eventually lead to the development of effective medical treatments. Anyone with whatever interest in cystic fibrosis will find these and other issues discussed in this delightful volume, which contains a lively and detailed review of the genetics of cystic fibrosis.


J A Kuzemko
Consultant child health