### Table 1 Mean haemoglobin concentrations in paired venous and skin puncture blood samples

<table>
<thead>
<tr>
<th>Haemoglobin range in venous blood (g/l)</th>
<th>Mean (SD) skin puncture haemoglobin (g/l)</th>
<th>Mean (SD) venous haemoglobin (g/l)</th>
<th>Difference (g/l)</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 90 (n=42)</td>
<td>84.1 (13.2)</td>
<td>79.5 (10.4)</td>
<td>4.7</td>
<td>-5.7 to 15.1</td>
</tr>
<tr>
<td>91-110 (n=94)</td>
<td>104.8 (7.5)</td>
<td>101.2 (5.0)</td>
<td>3.6</td>
<td>7.7 to 14.9</td>
</tr>
<tr>
<td>&gt; 111 (n=52)</td>
<td>121.4 (8.5)</td>
<td>119.1 (6.3)</td>
<td>2.3</td>
<td>8.7 to 13.5</td>
</tr>
<tr>
<td>All (n=188)</td>
<td>104.8 (16.1)</td>
<td>101.3 (15.6)</td>
<td>3.5</td>
<td>7.6 to 14.6</td>
</tr>
</tbody>
</table>

It seems unwise to assume the haemo-concentrations reported by Emond et al are lower than those that would have been obtained from the same children. Their method of sampling appears to be similar to our own, and given the bias to slightly higher values obtained with the Hemocue (assuming the values given by the laboratory analyst represent truth), it is possible that venous haemoglobin values in their population could be on average some 5 g/l lower than those reported for skin puncture samples.

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4 Coburn TJ, Miller WV, Parrish WD. Unacceptable variability of haemoglobin estimation on samples obtained from ear punctures. Transfusion 1977; 17: 265-8.

### Challenges in the management of childhood brain tumour

Dr Buss comments: There was a typographical omission from the reference for the APLS guidelines—hence the problem that Dr Ward encountered. The third reference should have ended: London: BMJ Publishing Group, 1993 (reprinted with revisions 1994).

We studied the current guidelines at the time (1994), and we stressed in our second paragraph that the ‘Guidelines for paediatric resuscitation published by the European Resuscitation Council (1994) are incorporated within the advanced paediatric life support protocols’. This directly infers that we were using the 1994 APLS protocols but the failure to indicate this accurately in the references was not picked up by ourselves or the referees and Dr Ward is to be congratulated for noticing this incongruity.

The controversy over the use of bicarbonate was clearly mentioned in the second part of our paragraph on asystole, and although results were included they did not affect overall figures for sequence failure. With regard to the use of a precardial thump—this has similar connotations to bicarbonate usage and in the scenario that we gave would be neither warranted or desirable.


### Sleeping position and cot death

**Editor,—** The trend of the incidence of the sudden infant death syndrome (SIDS) in Austria 1 strikingly resembles the one presented by Gilbert from England and Wales 2 (see figure 1). However, in our opinion there are several arguments against the widespread assumption of a causal relationship between the prone sleeping position and SIDS.

Firstly, it was at the 13th International Paediatric Congress in Vienna in 1971 that the assumed advantages of the prone sleeping position were first presented by the Austrian paediatricians Reisertbauer and Czermak. 3 If the prone sleeping position were to be blamed for the growing occurrence of SIDS, there may need the combined intervention of health professionals and parents, the latter using the rights for special needs education prescribed by the Child Act as a basis for their lobbying.

The United Kingdom Children’s Cancer Study Group (UKCCSG) has made considerable progress in developing audited, collaborative research protocols that will allow assessment of the relative merits of different treatments. There is a need for ever closer neurosurgical input into clinical trial development.

Such a reorganisation of facilities for childhood brain tumour would be greatly assisted by the development of specialist purchasing guidelines that define core standards of care. This process has been discussed by representatives of the paediatric neurological and oncological interest groups of the UKCCSG. Approval of all the relevant royal colleges is being sought. We hope that we can ensure more consistent provision service for UK children with brain tumours. Current inequalities in health service availability become too obvious when high profile cases seeking international referral hit the national headlines.

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### Paediatricians’ knowledge of cardiac arrest guidelines

Dr Edwards.—I would like to draw attention to an important inconsistency in the article by Buss et al. (1996). 1 Two references are cited that draw attention to the facts needed in a study of paediatricians’ knowledge of paediatric cardiac arrest guidelines. 2 However on examination of the protocols from the two sets of guidelines published in 1993 and 1994, there are a number of differences between them due to updating. In the 1994 ventricular fibrillation protocol a preliminary precordial thump has been added. 2 In the 1994 asystole protocol atropine has been removed completely, while it was an integral part of the protocol in 1993. 2 Also in the asystole protocol the giving of bicarbonate has changed from a necessity in 1993 to being just a consideration in the 1994 protocol. 2

Because of rapid updating of the guidelines there are at present two sets published and widely available, which have a number of differences. The study does not clearly specify which guidelines were used and the conclusions drawn are based on the fact that the two published sets are equivalent.

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### Figure 1 Mortality from SIDS and postneonatal mortality (PNM) in England and Wales (E/W) and Austria (A).

**PNM (A)**
**PNM (E/W)**
**SIDS (A)**
**SIDS (E/W)**

[Graph showing mortality rates]