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trary to popular belief, their venom is generally not very harmful, and bites caused by them are usually not much worse than wasp bites. However, when these animals feel threatened, they quickly flick off clouds of abdominal (urticating) hairs with their legs. These hairs are small, sharply pointed, and covered by hundreds of little hooks. They can cause severe itching when in contact with the skin, especially in the nose and eye regions.[1-5] Cooke *et al* showed that these urticating hairs can work themselves deep into human skin. They can also migrate into the cornea and cause intense irritation and granulomata formation (ophthalmia nodosa).[6] The retained hairs cannot be safely removed totally and may persist in the cornea for many months. The main mechanisms of injury are physical irritation and hypersensitivity. However, chemical irritation may also play a part. Treatment is with a prolonged course of corticosteroid eye drops. Antibiotics eye drops and mydratics may also be required.

We recommend that when handling tarantulas they are kept well away from the face and that warning should be given by the pet shops about this potential danger. The wearing of eye goggles and gloves when handling these spiders, whether dead or alive, is advisable.

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# WESTMINSTER BRIEFING

The following items are from *Children & Parliament*, June–July 1996. *Children & Parliament* is an abstracting service based on *Hansard* and published fortnightly by the National Children's Bureau while parliament is sitting. It covers all parliamentary business affecting children and is produced in either printed or CD-ROM form. Both are available on subscription from the Library and Information Service, National Children's Bureau, 8 Wakley Street, London EC1V 7QE (tel: +44(0)171 843 6035). (The *Hansard* reference is given first followed by the issue number and date of *Children & Parliament.*)

In England and Wales in 1995 there were 648 138 live births and 3600 stillbirths. Home births were about 2% of the total and almost 98% were delivered in NHS hospitals. About one in 200 was delivered in a non-NHS hospital or 'elsewhere'.

(10 June 96, Col 21-22; 239,25.06.96)

The number of child and adolescent psychiatrists in the NHS rose from 240 in 1979 to 300 in 1982 and 350 in 1990 but fell again to 330 by 1994. In the same years the number of child psychotherapists was 60, 70, 140, and 220.

(4 June 96, Col 385; 239,25.06.96)

The number of dedicated paediatric intensive care beds in England in 1994 was 196, giving one bed for around 54 000 children under 17. The ratio of beds to children varied from 1:34 296 in North Thames to 1:145 472 in Anglia and Oxford. These figures do not take into account provision for children in adult units or provision outside a region.

(7 June 96, Col 588-589; 239,25.06.96)

The number of women sentenced in English and Welsh courts in 1985 was 143 995; in 1994 it was 185 798. The proportion sentenced for violent offence was just under 3% in both years but the proportion given custodial sentences fell from 2.5% in 1985 to 1.6% in 1994. This was because non-violent offenders were much less likely to be sent to prison in 1994, although in both years just under 10% of violent offenders were imprisoned.

(5 June 96, Col 132-134; 239,25.06.96)

Deaths from solvent abuse have continued to fall; there were 71 in 1993 and 57 in 1994.

(24 June 96, Col 23; 240,9.07.96)

All age asthma mortality has fallen over the last five years but not childhood asthma mortality. Deaths at all ages fell steadily each year, from 3.6 per 100 000 population in 1991 to 2.7 in 1995 but in under 15 year olds mortality was steady at 0.2 to 0.3 per 100 000.

(8 July 96, Col 17; 241,22.07.96)

The Department of Health is currently spending about 6.5 million pounds annually to combat smoking, 5 million on drug and solvent misuse, and 825 000 on alcohol problems.

(1 July 96, Col 336; 241,22.07.96)

Young people in trouble with the courts can expect their cases to be dealt with in about 4.5 months on average. The average time from offence to completion varied in 1995 from 116 days in the north of England to 160 days in London.

(4 July 96, Col 496-498; 241,22.07.96)

Although girls do better than boys at GCSE the difference is much less for A level examinations and, in fact, boys get more grade A passes at A level while girls get more passes overall. The reasons for these differences are not clear but the Office of National Statistics is to collect more data.

(24 July 96, Col 339-340; 242,6.08.96)

More children are having their tonsils out. The number of tonsillectomies in NHS hospitals in England per 100 000 children under 17 has risen each year since the figures began in 1989, from 449 in 1989–90 to 534 in 1994–5. Over the same period the number of myringotomies has fallen but there has been no consistent change in the number of adenoidectomies (about 160–170 per 100 000 children per year).

(23 July 96, Col 219; 242,06.06.96)

Infant mortality rates in the European Union in 1993 varied from 4.4 per 1000 live births in Finland to 8.7 in Portugal; the UK rate was 6.6.

(16 July 96, Col 492-493; 242,06.08.96)

Perinatal mortality in England and Wales in 1994 varied considerably with the mother's country of birth, from 6.4 if the mother was born in Australia, New Zealand, or Canada to 17.4 if she was born in the Caribbean. For UK born mothers the rate was 8.6 and for mothers from the Indian subcontinent it was 9.3 (India), 10.8 (Bangladesh), and 15.0(Pakistan).

(16 July 96, Col 454; 242,06.08.96)

Data from Scotland show that, although only 6% of boys and 10% of girls measured at age 15 in 1987 were overweight or obese, by the time they were 18 the figures had risen to 17% and 22%. Obesity (body mass index (BMI) >30) was found in 0.9% of 15 year old boys and 1.6% of 15 year old girls and in 2.1% of boys and 5.7% of girls at 18. Underweight (BMI <20) fell in both sexes (boys 51% to 19%, girls 39% to 22%) between the two ages.

(22 July 96, Col 101-102; 242,06.08.96)

Each year in the 1990s the number of children killed in road cycling accidents in England has been between 37 and 50 and the number of non-fatal cycling injuries between 7349 and 8132. In Scotland there are 3–7 deaths and 462–625 non-fatal injuries per year.

(18 July 96, Col 660 (England);
23 July 96, Col 230 (Scotland);
242,06.08.96)

Some 22% of children in local education authority maintained schools and 13% in grant maintained schools in England are eligible for free school meals.

(22 July 96, Col 59; 242,06.08.96)

In 1993 road fatality rates for children in the European Union varied from 5.2 pedestrian and 2.3 car passenger deaths per 100 000 population in Portugal to 0.4 (pedestrian) and 0.9 (passenger) in Sweden. The rates for Great Britain were 1.4 (pedestrian) and 0.7 (passenger). The fall in total deaths from 3 to 2 per 100 000 in Great Britain between 1990 and 1994 has been largely due to a decrease in pedestrian fatalities.

(23 July 96, Col 153-154; 242,06.08.96)

# LUCINA

Infantile hypertrophic pyloric stenosis probably results from defective development of pyloric innervation. A developmental histochemical study in London (*Journal of Pediatric Surgery* 1996;**31**:490-7) has shown that both nitric oxide synthase (NOS) and vasoactive intestinal polypeptide (VIP) appear in the myenteric plexus and submucosa of the human pylorus by 12 weeks of gestation. In pyloric stenosis fewer ganglia expressed NOS but more expressed VIP. It is suggested that pyloric stenosis occurs after the start of oral feeding in infants who have a defect which is present as early as 12 weeks' gestation and which is characterised by reduced NO production. Increased VIP expression in the ganglia could be a compensatory mechanism since VIP induces NO release from the muscle cells. Pharmacological promotion of either NO or VIP activity could prove useful therapeutically.

*If a child has illness A which may or may not be associated with underlying condition B and A plus B may lead to complication C, is it important to detect condition B? Only if its detection will lead to prevention of the complication and the means of detection is itself harmless. Where A is urinary infection in a young child, B is reflux, and C is reflux nephropathy, the conventional answer to the question has been yes. But the tide may be turning. Micturating cystourethrography causes much distress* (European Journal of Pediatrics 1996;*155*:684-7) *and more selective use of imaging together with newer, less invasive techniques (see commentary,* Lancet *1996;***348***:71-2) may see its decline. Lucina wonders whether many of us may have been a touch ovine in our adherence to it. She would not regret its passing.*

Recent theory has tended to brand cytokines as the 'bad guys' of brain inflammation and treatment has been aimed against them. Now the issue seems much less clear (*Nature Medicine* 1996;**2**:746-7) and it appears that the cytokines may have a protective effect; perhaps protective in some circumstances and damaging in others. Work on mice lacking tumour necrosis factor (TNF) receptors has shown that the brains of these animals are particularly susceptible to insults such as stroke or seizures (*Nature Medicine* 1996;**2**:788-94). TNF may protect brain cells by inducing superoxide dismutase and consequently reducing oxidative damage.

*A recent report has concentrated on the skin features of tuberous sclerosis (*British Journal of Dermatology *1996;***135***:1-5). Of 131 patients only five had no skin features. In the remaining 126, depigmented spots were universally present under the age of 5 but they tended to fade or disappear with age being found in some 80% of 15–30 year olds and in 60% after 30. Adenoma sebaceum was not seen in children under 5s but was found in over 80% of those aged 5s to 14 and older. Shagreen patches affected 25% of under 5 and more than 50% after that age and ungual fibromas were uncommon before the age of 14 but affected 70% or more of adult patients.*

Age, sex, and pubertal stage related ranges for overnight urinary excretion of albumin, creatinine, and *N*-acetyl-beta-D-glucosaminidase have been derived from a study of 528 Manchester schoolchildren (*European Journal of Pediatrics* 1996;**155**:596-602). The excretion rates for all three substances increased up to puberty and boys excreted significantly more creatinine than girls both before and during puberty.

*The reported efficacy of BCG has varied worldwide and a report from Malawi poses difficult questions (*Lancet *1996;***348***:17-24). In that country BCG provides 50% protection against leprosy but none against tuberculosis. The new trial has shown that repeat BCG further reduces the risk of leprosy by another 50% but still does not protect against tuberculosis. The greatest effect against leprosy was with childhood vaccination. More worryingly, repeat BCG significantly increased the risk of pulmonary tuberculosis and this seemed to be specifically due to an adverse effect in HIV positive people. There is a dilemma: repeat BCG vaccination could reduce the incidence of leprosy considerably but might cause more deaths from tuberculosis especially in view of the HIV epidemic. The second consideration probably outweighs the first.*

Whether growth hormone treatment of children who are not growth hormone deficient is beneficial remains unclear. Data reported in the *Lancet* (1996;**348**:13-6 and 25-7) suggest that the resultant increase in final height for normal short children or girls with Turner's syndrome is probably modest. But these were not randomised trials and better answers should be available when the results of such trials currently in progress are published.

*Parents in developing countries still use aspirin for febrile children. In Kenya blood salicylate was detectable in all of 143 children with severe malaria and six had high levels (*Lancet *1996:***347***:1736-7). The symptoms of aspirin poisoning and severe malaria may be confused (both cause metabolic acidosis, hypoglycaemia, coma, and seizures) and aspirin may add to the morbidity of malaria. The Kenyan workers found that almost all preparations sold locally for childhood fever contained aspirin and high doses were common.*

In Beira City, Mozambique, estimated under 5 mortality fell from 246 to 212 per thousand over the 11 years up to 1989 despite the war (*International Journal of Epidemiology* 1996;**25**:349-56). Health services have improved, with more nurses, more measles vaccination, and more use of oral rehydration therapy. The main associations with child mortality were socioeconomic factors such as poverty, absence of father, young mother, and poor use of health services. Most risk factors were fairly insensitive, however, and the policy of concentrating services on 'at risk' children is questioned.

*Fifty one Finnish men aged* 16–28 *who had been treated at ages 10 months–12 years for unilateral or bilateral cryptorchidism provided semen samples (*Journal of Urology *1996;***156***:82-4). Poor sperm quality was found in three of 39 who had had unilateral and six of 12 who had had bilateral non-descent, all nine of whom had been treated after the age of 3. The three men with azoospermia all had high plasma follicle stimulating hormone concentrations. The 22 patients (17 unilateral, five bilateral) treated before the age of 4 all had fair or normal sperm quality.*