The Griffiths Mental Development Scales have a long and developing history in clinical practice and research. The scales have been used, alongside other measures, in many studies reported by this journal. A feature of the scales’ original development was the use of standard deviations for each scale based on a simple ratio transformation of the raw data: the mental age divided by the chronological age. As Table 1 shows, this yielded similar, but slightly different means and standard deviations for each scale, including the aggregate general quotient (GQ).

Comparing scale scores with each other is therefore prone to potential error, if they were considered equivalent. In many cases, especially where the scores are close to the mean, this error is minimal. However, the error is exaggerated as scores move away from the mean. This may lead to errors in interpreting Griffiths quotients, particularly where numerical cut-offs for popular developmental and ability ranges are applied to unadjusted scores.

Two solutions are suggested to ensure an informed comparison of scores between individual Griffiths scales and scores from different tests. The first alternative is to calculate an exact standard score equivalent (with a mean of 100 and SD 15). This is the most precise alternative.

Conversion of the Griffiths scale scores into standard scores can be carried out using a simple transformation algorithm,

$$SS_2 = M_2 - \left( \frac{M_1 - SS_1}{SD_1} \times SD_2 \right)$$

where $SS_2$ is the new adjusted standard score ($M_1$, $SD_1$), $M_2$ is the mean of the normal standard score (100), $M_1$ is the mean for the Griffiths subscale or GQ, $SS_1$ is the Griffiths standard score, $SD_1$ is the standard deviation for the Griffiths’ subscale or GQ and $SD_2$ is the normal standard deviation (15).

The second option is to develop descriptive category ranges for Griffiths scores that are equivalent to those used by other tests. Table 2 uses standard score ranges (±2 $SD$) that are based on those used by popular tests with a mean of 100 and $SD$ 15, for example, the Wechsler Preschool and Primary Scale of Intelligence—revised, and the British Ability Scales II. Descriptive terms for the score ranges, such as “borderline” or “low” for scale scores of 70–79, and “normal” or “average” for scaled scores of 90–109, refer implicitly to this shared standard. The same score ranges are used by the Bayley Scales of Infant Development.

Table 3 shows the downward extension of these ranges, with the Griffiths scale score bands for the ICD10 mental retardation ranges. The table highlights the difference between Griffiths subscale scores at the extreme ranges.

These tables and transformations are suggested as simple corrections to potential interpretation error based on the traditionally derived Griffiths standard scores.
A previously healthy 2½ year old boy with varicella infection presented five days later with high fever, productive cough, and dyspnoea. On admission, he had signs of respiratory distress and poor perfusion. He was pale and dyspnoeic, with a temperature of 41.2°C and 96% saturation in room air. Lung auscultation revealed bronchial breath sounds in the right upper field. Resolving lesions typical of varicella were seen on skin examination. The rest of the physical and neurological examination was normal. Chest x-ray showed consolidation in the right upper lobe with air bronchogram. A diagnosis of lobar bronchopneumonia was made and IV ceftriaxone was started. On day 5, chest x-ray showed an airspace lesion in the anterior segment of the right upper lobe. A complete recovery was noted, indicating a free fluid containing cavity (figs 1 and 2). Antibiotic treatment was continued for four weeks, leading to complete clinical resolution. No invasive procedure was performed. Chest x-ray performed three weeks later showed complete resolution. No invasive procedure was required.

Lung abscesses are circumscribed, thick walled cavities in the lung containing purulent material. Diagnosis is usually made on the basis of characteristic roentgenographic findings. The abscess cavity becomes visible when air entering from the bronchus creates an air-fluid level over the pus and may be missed if only a supine film is taken. Diagnosis is usually made on the basis of characteristic roentgenographic findings. The abscess cavity becomes visible when air entering from the bronchus creates an air-fluid level over the pus and may be missed if only a supine film is taken.

REFERENCES