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artery pressure. However, cold stress may itself cause a rise in pulmonary artery pressure which is independent of dehydration, and additive with, the rise in pulmonary artery pressure caused by hypoxia. An environment that is comfortable for an adult may cause cold stress to a baby. In winter therefore a neonate could be exposed to several factors which contribute to a raised pulmonary artery pressure. In the aetiology of systemic hypertension it has been suggested that prolonged or repeated rises in pressure may result in hypertensive crisis and the situation may arise with pulmonary artery pressure.

In the case reported by Dr Dunne and colleagues there appeared to be immaturity of hypothalamic function affecting respiratory and temperature control, but the importance of their report may lie in the fact that there are likely to be other cases where the hypothalamic functional immaturity is more minor and, though not clinically evident, may contribute to sudden infant death through an effect on the pulmonary artery pressure.

E L Lloyd

Department of Anesthetics, Princes Margaret Rose Hospital, Edinburgh EH10 7ED


Immunisation rates and the good practice allowance

Sir,—We share the concern of Dr David Mant and colleagues (18 October, p 995) about the apparent failure of the child health services committee to reflect accurately the immunisation rates for children in the area. We report similar inaccuracies observed in our own inner city practice in St Paul's, Bristol.

We have worked hard to increase the uptake of immunisation in the under 5s, and despite the deprivation in the area and a highly mobile population (20-6% patient turnover), uptake of immunisations has increased by 15% in three years. Ninety five per cent of children are up to date with diphtheria, tetanus, and polio immunisations, and 93% have been immunised against measles. These figures were obtained by checking the practice and health visitor held notes of each child, as immunisations are recorded on both sets of notes. They are not supported by the child health services computer, which shows figures of 86% and 76% respectively.

We are investigating the discrepancy with the child health services but suspect that it is related to high patient mobility in the inner city. While the practice can monitor patient movements promptly (principally through health visitors contact), the family practitioner committee and child health services are less likely to be aware of them; patients are often slow to update changes of address or to reregister with a doctor in a new area.

We would encourage other practices to audit their uptake of immunisations and compare them with the child health services computer figures. There are two likely benefits. Firstly, and most importantly, immunisation rates may be increased, as children in need of immunisation will be identified from practice notes. Secondly, if our findings of discrepancies are substantiated by others (particularly those in inner city areas), a much needed lobby to improve data transfer between practices and family practitioner and child health services will emerge. This can lead only to better services for the under 5s.

Finally, while agreeing that high uptake of immunisation can reflect good medical practice, we are sceptical that acceptable levels of uptake can be measured in order to attract a good practice allowance; improving uptake in one’s own practice should be reward enough.

John James
Carol Clark
Montpelier Health Centre, Bristol BS6 3PT


Homerton Hospital

Sir,—Homerton Hospital, Hackney, has indeed admitted its first child (6 November, p 962).

Among early arrivals were known carriers of multiply resistant (including methicillin resistant) Staphylococcus aureus transferred from the old Hackney site. Not surprisingly the organism spread. This led to the cancellation of all non-emergency admissions and operations for the first three months after opening, to compound the three months without such admissions during the run down period of the old site.

Making up this six month backlog is proving difficult because the hospital is too small—emergency admissions and the inevitable long stay elderly patients have already virtually filled the hospital. The casualty department is regularly closed adressing admissions each day for lack of beds; the problem will, of course, get worse as winter comes. Ruthless “bed management” can go only a certain way towards preserving beds for waiting list patients.

The inadequate provision of facilities extends beyond bed numbers. There is a shortfall of rooms for resident doctors. More telephones are needed but the switchboard equipment is already full. The antenatal clinic waiting area had only a dozen seats initially, though more are appearing in the corridors.

It is a great pity that the hospital’s potential will never be realised. It is symptomatic of the “economies” being inflicted on the health service, which have now adversely affected patient care and staff morale.

T J Hoare
London N7 0AD

Mrs Wendy Savage and the report of the Munro inquiry

Sir,—I write to thank you for publishing the Munro report and recommendations in full, which has enabled our readers to judge at first hand the proposed arrangements at the London Hospital instead of having to rely on incomplete and often misleading accounts in the lay press. Mrs Savage has already indicated her acceptance of the detailed proposals and at the time of writing we are waiting to see if her colleagues will do the same.

There is one point, however, which requires further comment. Unfortunately the report and remarks the Munro panel makes observations about the origins of this affair and the background to Mrs Savage’s suspension. While we do not take specific issue with these remarks, there is a great deal more to the genesis of the HMI(1:112) inquiry than the simple lack of “a broad consensus on operational policies.”

The Munro panel’s terms of reference did not allow it to go deep into this point, but those of your readers who wish to read in detail are therefore likely to be able to do better than read Mrs Savage’s book A Savage Enquiry—Who Controls Childbirth? published recently by Virago. All the net royalties from the book are to be placed in a fund for research into women’s health and the exercise of patient choice.

Brian Raymond
Bridsmen and Partners, Solicitors, London NW1 2SU

Drug points

Malaria prophylaxis

Dr A G Bynoe and J K Bynoe (South Milford, Yorkshire LS25 5AQ) write: Our recent experience may shed some light on one aspect of poor compliance with malarial prophylaxis (11 October, p 932). For a recent trip to India with our 2 year old son we were recommended to take proguanil and chloroquine. The malaria reference advice suggested that chloroquine syrup was probably accepted by children, and we embarked on trying to get our son to take the tablets already cut and tipped into a small bowl and left uncovered. The accomplished pill taker can overcome the immediate and strong taste by swallowing. The child cannot. Our first attempt, after failing with persuasion, cajoiling, deception, bribery, threats, and physical violence, resulted in most of us in tears, with food over the walls and chloroquine everywhere but in the mouth. Later attempts to try the manufacturer’s suggestion of crushing the tablets in jam or honey were just as futile, as crushing the tablet releases so much bitter, ranky, and unsavoury, that even the smallest child might find them unpalatable.

Before proceeding to the picture, the our successful method was to halve the tablets to manageable size and roll them in butter. We know from experience of oral chloroquine prophylaxis that our son had previously been taught to take tablets; we had a struggle which was ultimately successful. We wonder how many other tourist children are being put at risk for want of an acceptable formulation of chloroquine? What price film or sugar coating?

Dependence on dextromethorphan hydrobromide

Dr Martin W Orrell (Department of Forensic Psychiatry, St George’s Hospital, London SW17) and Patrick G Campbell (University College Hospital, London WC1) write: Like the patients in Dr Philip Fleming and colleagues’ (6 September, p 597) we have recently seen a patient who was dependent on dextromethorphan. This 37 year old man had a history of abusing a wide range of drugs and had been diagnosed as schizophrenic. Over the past year he had abused a cough linctus containing dextromethorphan, consuming up to two bottles several times a week. He had been seen by various workers suffering from feeling anxious and aggressive; after a week on antipsychotic medication his mental state improved, but his mood swings and occasional aggressive outbursts were large, bitter, and disruptive. Both times he admitted to having taken a bottle of the cough linctus containing dextromethorphan. We have asked Dr Fleming if he found dextromethorphan was responsible for our patient’s psychosis or merely exacerbated it, but we are worried about its psychological effects. Two cases of psychosis due to dextromethorphan have been reported.