

Paediatric surveillance

Sir,

I have just received the new proforma for paediatric surveillance launched by GMSC and the RCGP, and have also noted Dr Donald's and Dr Wilson's comments welcoming suggestions for improvements. (Pulse 1984; Oct 27: 10.)

First, while results of neonatal screening of phenylketonuria (PKU) and thyroid levels are represented on the proforma there is no space available for cystic fibrosis testing, yet the latter has been performed routinely in Northern Ireland since August 1983 on the standard heel prick. Surely it deserves a place on the surveillance card?

The centile charts are calibrated from 0-5 years in three graphs on two separate pages using 20 x 16 cm of space (Lloyd George format). Each graph would contain only two or three readings at the standard assessment ages for the vast majority of (normal) children. While pictorially interesting, it is insufficient of space, and the same functions could be charted in tabular form for the 'standard' age groups. One possible alternative is illustrated on Table 1.

Actual values can be added below the 'normal' values as on a 'sliding scale', thus being easily interpreted, and saving space. Centile graphs may be kept for 'problem cases' as they arise.

Thirdly, there is no specific space allocated for the use of 'open-ended questions': Is the baby/child happy? Is mother enjoying the baby/child? We have found that their routine use often unmasks covert problems. I feel it would be appropriate to have a small section to include the above, along with the 'infectious diseases' table, space for a medical history summary, and details of bladder and bowel function (at present inappropriately in the physical examination table). All these could be loosely termed 'history'.

While the overall format of the card is fairly comprehensive, it is somewhat too bulky in the Lloyd George folder. With the above measures concerning the centile charts, and with pruning of other non-specific sections (special factors, other agencies, additional comments), a reduction of 25 per cent would be easily achieved with little sacrifice.

Having used a surveillance proforma containing a similar format, I welcome the new publication for wider debate, and feel it is near the realistic end-point. My only fear is that it will be preaching to the converted. Let us hope that by the time item-of-service payments are introduced, preceding widespread uptake of paediatric surveillance, the optimum format will have been decided.

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Table 1. Paediatric surveillance: suggestion for charting head circumference, weight and height

GIRL				
Head circumference (cm)				
Age	3	50	97	
Birth	33	36.5	39	
7/52	36	39	41.5	
7/12	41	43	46	

Weight (kg)

Age	Centile		
	3	50	97
Birth	3	3.5	5.5
7/52	4	4.7	7
7/12	6.2	7.7	9.8
2½	10.7	13.2	16
4½	14	16	21.4

Height (cm)

Age	Centile		
	3	50	97
2½	82.5	89	96
4½	95	103.5	113

Using the age-sex register to code preventive procedures

Sir,

Increasing awareness of the College's prevention initiative, and financial incentives, are encouraging more general practitioners to use their age-sex registers for prevention procedures. This is witnessed by the large number of articles and letters in recent journals and the free medical newspapers. One recent letter suggested using a coloured dot on the age-sex card to identify those girls who have had rubella immunization.

The College suggests marking a cross in each of the row of numbered boxes along the bottom of the cards thus:

- 33 First triple and polio
- 37 Second triple and polio
- 38 Third triple and polio
- 39 Measles vaccine
- 40 Pre-school booster
- 41 Rubella
- 44 et seq. Quinquennial cervical smear from age 35 (to which we add blood pressure, weight, urine, smoking and tetanus — which we also offer to men)

I considered using a machine to punch a row of holes in the boxes, which would then be coded by biting the bottom of the hole off with a ticket punch. The age-sex register would then be used as a punched card system. A prototype machine revealed the difficulty of punching such a large number of holes, and also revealed a between batch variation of up to 3 mm in width of cards, which rendered its use impractical.

We are now evaluating the use of a ticket punch alone to mark the relevant box, as the corresponding procedure is performed. This has the advantage of showing marked cards when viewed, en bloc, upside down. Those who have been missed are thrown into prominence, and an impression of the percentage uptake is available at a glance.

May I commend the use of these numbered boxes, as on-