

## 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.

B.W. MITCHELL

Randalstown Health Centre  
Neillsbrook  
Randelstown  
Co. Antrim

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

| GIRL                    |    |               |      |
|-------------------------|----|---------------|------|
| Head circumference (cm) |    |               |      |
| Age                     | 3  | Centile<br>50 | 97   |
| Birth                   | 33 | 36.5          | 39   |
| 7/52                    | 36 | 39            | 41.5 |
| 7/12                    | 41 | 43            | 46   |

Weight (kg)

| Age   | 3    | Centile<br>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 | 3    | Centile<br>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-

ward transmission of the card with the medical record is recommended, and conforming to the standard system leaves less room for errors in interpreting other practices coding.

R.S.L. THOMAS

The Surgery  
Heath Hill Road  
Crowthorne  
Berkshire RG11 7BN

NB: Ticket punch made to special order by, Thomas Newey Ltd, 22 Regents Place, Birmingham B1 3NJ. Tel: 021 236 1761.

## Care of the foreskin in infancy

Sir,

A survey has recently been performed at Southampton on the instructions given to mothers about the care of the foreskin. This showed that only 29 per cent of mothers were given the correct advice, 33 per cent were given incorrect advice and the rest received no advice. Only 66 per cent of those giving advice — both doctors and nurses — knew what the correct care should be.

It is now generally accepted that the optimal management of the infant's foreskin is masterly inactivity until the child is out of nappies and that by the age of three, 80 per cent of foreskins will be retractile.<sup>1</sup> Thereafter, gentle retraction while washing in the bath will allow separation of the normal preputial adhesions. Premature retraction causes radial splitting of the foreskin, with healing by fibrosis and subsequent development of a phimosis. This results in an avoidable circumcision.<sup>2</sup> It is worrying that there are so few mothers who receive the correct advice, considering the large number of medical and nursing staff they see. In addition, it is sad to see that one-third of mothers were advised to prematurely retract the foreskin.

The advisers themselves were confused about both the correct management and who should be responsible for ensuring that mothers were correctly instructed.<sup>1</sup> The health visitor has a statutory duty to visit the mother and child at 10 days, and then is available during the first 13 months while the child is immunized. She should also review the child at about 18 months and three years. She is therefore perfectly placed to insure that mothers learn the correct management of the foreskin and thus reduce maternal anxiety and the numbers of avoidable circumcisions, together with ensuring a lifetime of routine penile hygiene.

MERVYN GRIFFITHS

John Radcliffe Hospital  
Headington  
Oxford OX3 9DU

### References

1. Gairdner D. *The fate of the foreskin*. *Br Med J* 1949; 4: 1433-1435.
2. Twistington-Higgins T, Williams DI, Ellis-Nash DF. *The urology of childhood*. London: Butterworth, 1951.

## Fluoridation update

Sir,

Since the article by Mr G. Smith (June *Journal*, p.350) was restricted to the medical aspects of fluoridation — some of which, to me, seemed misleading — it would have been inappropriate to have introduced an entirely different topic 'The moral issue' into my reply, which was a simple statement of scientific fact.

Replying to Dr Juby's letter (November *Journal*, p.626), much of the river and spring water in the world is drinkable in its natural condition, provided one is prepared to risk contracting cholera. The water authorities, however, without reference to the freedom of choice of the individual, who could add chlorine tablets to his natural drinking water if he so wished, add free chloride ions to the water supply at source.

Similarly, the individual, who could add fluoride tablets to his artificially chlorinated drinking water or to his natural spring water if he so wishes, may choose to feed fluoride deficient water to his children, provided he is prepared to risk their contracting dental caries.

Just as water authorities provide protection against microbial enteritides by default so they wish to provide protection against dental caries by default. There is no 'moral' objection to the principle of extending a service which is already accepted by society. There is only an emotional repugnance at what might seem to be 'Big Brother' who is removing our freedom to make our children suffer if we so choose.

The anti-fluoridationist is surely one of the greatest 'friends' of the dentist's bank manager since he is ensuring that there will always be plenty of disease for him to treat.

HUGH WALTERS

Torbay Hospital  
Lawes Bridge  
Torquay TQ2 7AA

## Doctors and nuclear war

Sir,

Dr Watts raised a most important matter in his letter (November *Journal*, p.628). As a profession we are totally unprepared for nuclear war, and the RCGP adopts an uncharacteristic head-in-the-sand attitude to the whole question.

At the Annual General Meeting on 10 November, after an eloquent address from the Chairman of Council in which members were exhorted to 'anticipate medical needs, rather than await events and then respond if we have to', a motion asking the College to produce a booklet for general practitioners and a leaflet for patients on the medical problems arising from nuclear war was so mutilated by amendments that in its final form it was virtually meaningless. This was a shameful exercise which did the College no credit.

Where else should we turn for guidance if not to our own academic body? For, make no mistake, guidance is sorely needed, and our present concern with matters like deputizing, prescribing habits, record-keeping and so on pales into insignificance compared with the almost unimaginable changes in the doctor's role which would follow a nuclear exchange, however small. How many of us are ready to work under military command, with few or no resources, and certainly without such luxuries as professional freedom or individual conscience? It seems likely that the major task facing any surviving doctors will be to choose those few casualties likely to benefit from what little treatment is available, and separate them from the majority who must be left to die. Simple humanity will impel us to offer some form of euthanasia to those we cannot help in any other way, but precious drugs and ammunition cannot be used up in this non-productive manner. What then shall we do?

Unless we begin to prepare now, to plan and to explain our plans to the public, we shall fail in our duty. Let wiser councils prevail than those which were heard on 10 November.

JOHN HODGSON

794a Washwood Heath Road  
Ward End  
Birmingham B8 2JN