

after 12 months and two after 18 months. The mean time required for the first contact was 30 minutes, and 10 minutes for each follow-up session. All the participants preferred 24-hour recall to 24-hour urine collection.

Patients' recall of sodium intake was constantly underestimated compared with the values obtained from urinary sodium excretion, while the change in sodium intake after 12 and 18 months was overestimated (Table 1). Patients' recall of potassium intake was constantly overestimated compared with urinary potassium excretion values. The standard deviations of the differences between the two measures, cross-sectional as well as longitudinal, were relatively large. The correlation coefficients were weak.

Large discrepancies were found between the estimated intake of sodium and potassium and that in the urinary excretion. The large standard deviations and the weak correlation coefficients indicate the low accuracy of the 24-hour recall on an individual level. There are various sources of bias in dietary measures. For example, the underestimated sodium intake might be caused by participants exaggerating their adherence to the diet. In addition, inadvertent errors in estimating portion size might contribute to the observed inaccuracy. Excretion of potassium in the stools, may explain why patients apparently overestimated potassium intake.

This study was carried out in one general practice and the results should therefore be interpreted with caution. The 24-hour recall, as expected, was more popular with patients than collection of urine. However, this pilot study shows that

using recall as a method of assessing sodium and potassium intake, even with the help of a dietitian, results in considerable inaccuracy.

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Sudden infant death syndrome

Sir,

The recommendations proposed by Moulton and Brown (letters, October *Journal*, p.431) in the hope of minimizing the risk of sudden infant death syndrome are echoed by the Care of Next Infant (CONI) programme at Sheffield Children's Hospital. This is being used by many health authorities to develop practical help and professional support for every family with their subsequent babies after a cot death. Such schemes and recommendations are undoubtedly well intentioned, however, they should be regarded with caution.

The Care of Next Infant scheme involves support which might include visits from a health visitor, an exhaustive daily symptom diary to be completed by the parents, daily weighing, apnoea monitors, room thermometers, and advice about clothing and wrapping of babies. There is no evidence to suggest that any of these measures reduce the likelihood of subsequent cot death. Although health visitor support is likely to be beneficial, regardless of the aetiology of sudden infant death, the other measures, and apnoea

monitors in particular, are liable to raise anxiety levels and dependence in a very vulnerable group of parents.

Moulton and Brown's recommendations for prevention of cot death are, as they admit, 'based on unproven aetiology', and may be criticized for giving unquantified advice, and recommendations that are too vague. In contrast, the advice outlined in the Care of Next Infant scheme gives enormous detail which may only cause confusion and worry for parents.

We are unable to give parents accurate, meaningful instructions as we do not really understand the aetiology of cot death. One wonders, therefore, who all this advice is benefiting. Parents, dreading cot death as the cruellest tragedy or perhaps even a reflection of their own care, will tend to accept, unquestioningly, advice proffered by health professionals. However, it may be that health professionals, in an area as emotive as cot death and in an era when omniscience and intervention are the norm, cannot come to terms with appearing impotent or ignorant.

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Stroke and the carer

Sir,

Drs Cassidy and Gray succinctly summarize the small but growing literature about the financial, marital and family problems faced by the carers of stroke patients.¹ Depression is considered to be a consequence of caring for a stroke patient, although the prevalence of depression in carers is, in fact, similar to that found in 'ordinary' samples of elderly people.² It is likely that other problems of caring which are less commonly measured, such as anxiety or loneliness, may be more important aspects of quality of life to examine than mood alone. The positive side of caring must not be overlooked, since many carers may feel that their lives have been enriched by the process.³

Drs Cassidy and Gray hint at the potentially complex relationship between the physical and emotional health of the patient and the carer. Unfortunately, evidence in this area is lacking. For example, the Edinburgh stroke unit study was quoted,⁴ in which the loss of functional independence of patients was attributed to overprotection by their carers, but no

Table 1. Sodium and potassium intake before and after dietary intervention as estimated by 24-hour urinary excretion and 24-hour recall.

	No. of patients	Mean (SD) concentration (mmol per 24 hours)		Mean difference (SD)	r
		Excretion	24-hour recall		
Sodium					
At 0 months	30	153.3 (53.3)	129.9 (50.5)	23.4 (62.6)	0.25
At 12 months	30	132.4 (69.7)	101.5 (77.1)	30.9 (89.9)*	0.30*
At 18 months	28	131.1 (52.5)	99.7 (49.9)	31.4 (71.0)*	0.05
0 months-12 months	30	20.9 (66.2)	28.5 (72.6)	-7.6 (77.6)	0.39*
0 months-18 months	28	21.0 (57.5)	30.8 (47.9)	-9.8 (59.6)	0.39*
Potassium					
At 0 months	30	76.9 (27.8)	110.7 (30.5)	-33.8 (28.4)**	0.53**
At 12 months	30	79.5 (28.2)	102.5 (27.1)	-23.0 (34.8)**	0.21
At 18 months	28	71.3 (27.2)	105.9 (31.7)	-34.6 (30.7)**	0.46**
0 months-12 months	30	-2.6 (23.1)	8.2 (30.3)	-10.8 (40.8)	-0.15
0 months-18 months	28	6.2 (23.5)	4.7 (32.9)	1.5 (35.8)	0.23

* $P < 0.05$. ** $P < 0.01$. SD = standard deviation.