

had increased to only 15% at 20 years. As would be expected, mortality is higher in infants with coexisting congenital heart disease than in those with isolated heart block.⁵ The causes of death are Stokes-Adams attacks or congestive cardiac failure.

Nevertheless, the asymptomatic infant with heart block still has a guarded prognosis even after the first year of life. In Esscher's series there was a 6% mortality between the ages of 6 months and 15 years and 18% of her patients required pacemakers because of syncopal attacks or heart failure.⁹ As patients reach adult life an increasing number develop symptoms and require pacemakers.^{3,11} The management of congenital complete heart block has improved enormously with the advent of small longlasting pacemaker generators—but there are still considerable technical problems in permanent pacing in small children.¹² Pacing is mandatory in the presence of Stokes-Adams attacks or heart failure and may improve exercise tolerance if this is limited by a slow heart rate. Many patients with congenital heart block, however, can increase their ventricular rate satisfactorily on exercise and so remain asymptomatic. Can we identify which of them is at risk of sudden death?

Most authors suggest that the likelihood of symptoms is inversely related to the ventricular rate. All the patients who died in the neonatal period in one study had a rate below 60 a minute,⁹ and the mean ventricular rate in other series was lower in patients with symptoms than those without, in both childhood and adult life.^{7,11} Ambulatory electrocardiographic monitoring has shown episodes of profound ventricular slowing at night,⁸ though the prognostic relevance of this is unknown. Location of the site of the block by intracardiac recording was of no help in predicting the risk of syncope, though block in or distal to the bundle of His was associated with a slower ventricular rate than proximal block.⁷

Molthan *et al*¹³ described three deaths in patients with widening of the QRS complex and QT interval; two had episodes of ventricular tachycardia or fibrillation as well as ventricular standstill. Esscher⁹ observed a corrected QT interval of over 0.44 second in 84% of patients with symptoms. Patients with congenital heart block have a higher incidence of ventricular ectopic activity on exercise than controls, the incidence being particularly high in those with QRS widening.¹⁴ These results raise the possibility that some of the sudden deaths in patients with congenital heart block arise from ventricular tachyarrhythmias rather than asystole.

At present, then, permanent pacing is indicated for patients with congenital complete heart block if they have episodes of syncope, dizziness, heart failure, or impaired effort tolerance. The remainder need careful lifelong follow up. Future studies may show the need for prophylactic pacing in asymptomatic patients with a slow ventricular rate or a prolonged QRS or QT_c interval.

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The sticky eyed infant

A sticky eyed infant will worry his parents and should concern his doctor—for prompt and appropriate treatment is called for.

Conjunctivitis in the neonate presents with redness, discharge, and sometimes watering; the condition is known as ophthalmia neonatorum and was once a major cause of neonatal blindness in the West.¹ The severe corneal damage caused by infection with *Neisseria gonorrhoeae* led to the use of the Crédé prophylaxis with silver nitrate drops, and this reduced the rate of ophthalmia neonatorum in infants born to infected mothers to less than 2%.² For many years now most European countries and much of the United States of America, however, have abandoned the use of routine prophylaxis, because of the occurrence of chemical conjunctivitis from the silver nitrate drops themselves and the introduction of reliable diagnostic facilities.³

Nevertheless, ophthalmia neonatorum remains common.⁴ Culture of the discharge may allow a specific diagnosis to be made. *N gonorrhoeae*, *Staphylococcus aureus*, *Streptococcus viridans*, and *Haemophilus* spp are established bacterial pathogens, but in recent years *Chlamydia trachomatis* is being detected more frequently⁴ and accounts for many of the infections resistant to chloramphenicol. Material from a conjunctival swab should be examined with a Gram stain and cultured for both bacterial and viral pathogens in all severe cases, all those where the mother is known to be infected, in the presence of any corneal damage, or in infants who have not responded to treatment. Probably the most effective antibiotic to use initially is 1% chloramphenicol ointment given six times daily; in patients shown to have infection with chlamydia tetracycline ointment may be given to the baby⁵ while his mother is treated with erythromycin.

The second common cause of a watering eye in a baby is obstruction of the nasolacrimal duct, which occurs in nearly half of all newborn babies but causes symptoms in very few.⁶ The affected eye waters, especially in the cold or wind, and is prone to infections, often by organisms of low pathogenicity. Sometimes a mucocele of the lacrimal sac develops or may be present at birth⁷; it may be detected by firm but gentle pressure medial to and below the inner canthus, which will express mucus or pus into the conjunctival sac. The obstruction to the nasolacrimal system is usually at the lower end of the nasolacrimal duct and is a result of incomplete development.⁸

Usually the signs and symptoms resolve spontaneously in the first few weeks or months and expectant management should be the rule. Massage over the lacrimal sac will raise its hydrostatic pressure and the parent should be instructed in gentle but firm massage from above the inner canthus downwards along the base of the nose. If the discharge becomes excessive a circumscribed course of antibiotic eye ointment should be given, preferably after culture of the discharge. The decision whether or not to syringe and probe the nasolacrimal duct is based on the severity of the watering and discharge, the length of time that has been allowed for spontaneous resolution, and the general health of the baby. As much time as possible should be allowed for spontaneous resolution—even up to a year—provided that the symptoms are not severe. Most British ophthalmologists prefer to carry out the operation under general anaesthesia, but it can be done without anaesthetic in smaller babies. Probing is successful in over 90% of patients with simple membranous obstruction of the distal end of the nasolacrimal duct,⁹ but is less successful in patients with obstruction at other sites, which are fortunately much rarer. Failure to respond to two separate probings may call for the use of a silicone tube attached to two stainless steel wires which are passed down the nasolacrimal duct. The tubing is left in the duct for a few weeks, tied with a suture in the nose to prevent its loss.¹⁰ With appropriate early treatment and care and gentleness in any surgical manoeuvres more extensive surgery is now rarely needed in childhood for congenital nasolacrimal duct obstruction.

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terms of age, sex, where he comes from, how long he has been in post, and where he intends to go, there is the simple question of which doctor is occupying which job; and even this presupposes reliable information about exactly what jobs exist.

The disadvantages of not having better information about medical staff have been acutely apparent to those concerned with postgraduate training and were clearly seen by the House of Commons Select Committee.¹ Twelve years ago one postgraduate dean set up an "operations room" with a wall chart purporting to describe the occupant of every junior hospital post in his region; he found that he needed a full time secretary to try to keep the information up to date, and the attempt was not a complete success. More recently, the postgraduate dean's office of the South West Thames region has pioneered a computer based information system for junior hospital posts and their occupants—a notable achievement, but the constant updating of any independent system of this kind must prove expensive in time and effort. Some other regions—all too conscious of their need—have begun to develop systems along the same lines as South West Thames but with variations of style and management. In fact, style and management are everything, for the way in which the potential usefulness or meddlesomeness of a data system is perceived, and the practicability of running it, will certainly determine its success.

In principle, the National Health Service coding system for regions and districts and for specialties and subspecialties can be used as the basis for a system of identification and coding of hospital posts. Some years ago the Council for Postgraduate Medical Education proposed such a coding system. There were untidy problems around the edges concerning part time and other supernumerary appointments, university posts with NHS grading, secondments, and rotational training programmes, but these are not insuperable. The proposals were discussed but not implemented. Meanwhile, the Royal College of Physicians has devised its own code numbers for posts recognised for training by the college and the Joint Committee on Higher Medical Training, and some other colleges are developing computer based information systems for their own specialties.

At the request of the Chief Medical Officer, Mr J C C Smith, formerly of the Department of Health and Social Security and now with the Nuffield Provincial Hospitals Trust, produced constructive suggestions for setting up a medical manpower information system which would be based at regional and district level. The mutual compatibility of these regional and district systems would make it possible to construct a national data base for medical manpower, and the DHSS would be an obvious customer for this information. John Smith's proposals were warmly welcomed, not least by postgraduate deans. The compilation of three sets of information was envisaged: about posts, people in posts, and the history of those who had previously occupied each post. In addition to these recommendations John Smith's report contained a brilliantly written analysis of the problems of the career structure and the consequent need for better data, which deserved to be very widely read.

Hopes that an integrated NHS/DHSS system can be developed have been raised by the report of the Körner Working Group E on manpower information.² The recommendations are very much in line with John Smith's but at a less ambitious level. In other words, the attempt has been made to define a sensible and practicable minimum set of data which could be compiled at district and regional level

Medical manpower information

A former senior administrative medical officer who wanted to telephone one of his clinical colleagues was said to refer to a file in his office which told him where any consultant in his region would be at any time on any day of the week. How often he turned out to be misinformed is not on record. Yet consultants are easy game for a medical manpower information system, compared with senior house officers and registrars. With junior doctors the problem is several stages further back than knowing where they are at a given time. Indeed, before knowing who a registrar or senior house officer is, in