

in reducing the first occurrence of neural tube defects.⁴

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Screening for diabetes during pregnancy

EDITOR,—R J Jarrett expresses many concerns about the existence of gestational diabetes.¹ One difficulty not mentioned arises from the definition of gestational diabetes, which includes abnormal glucose tolerance arising in or first detected in pregnancy. A consequence of this is that women with undiagnosed non-insulin dependent diabetes, which is potentially as risky for the pregnancy as insulin dependent diabetes, are lumped together with women who have abnormalities of glucose tolerance that are trivial so far as the index pregnancy is concerned.

This is not an important issue for women of European origin, in whom non-insulin dependent diabetes is quite uncommon during their child-bearing years, but in other ethnic groups it is a concern. In our clinic we have managed 262 pregnancies in 203 women with diabetes over the past five years, 143 of whom had non-insulin dependent diabetes. Of these, 85% were of Maori, Pacific Island, or Indian origin: these are ethnic groups with a high prevalence of non-insulin dependent diabetes.² Screening for gestational diabetes is practised in Auckland, and of the 143 women with non-insulin dependent diabetes, 87 were first found to have diabetes on screening in pregnancy; the disease was confirmed after delivery.

Using a composite score derived from factors significantly associated with the persistence of diabetes after delivery, we can now distinguish, with a high degree of certainty, women with non-insulin dependent diabetes from others with "gestational diabetes" at the time gestational diabetes is diagnosed (A Knox *et al*, New Zealand Society for the Study of Diabetes, 1992). We believe, therefore, that for communities like ours, in which unrecognised non-insulin dependent diabetes is fairly common in young people, screening for gestational diabetes is justified. Furthermore, at risk pregnancies can be defined accurately and treated accordingly; thus the requirements of a good screening test are fulfilled.

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Management after life threatening events in young children

EDITOR,—Martin P Samuels and colleagues' paper on diagnosis and management after life threatening events in infants and young children who received cardiopulmonary resuscitation suffers from the fact that the hospital provides a tertiary referral service and probably sees problematic cases.¹ Since 1977, when a detailed inquiry into child deaths was instituted in Gwynedd, no children admitted for life threatening events in the first four years of life have subsequently died (apart from two children with known epilepsy who have died during fits). Some of our children classified as having died of the sudden infant death syndrome may have been suffocated, but none of them presented to hospital before their death if that was so. And people who strangle their infants, thus causing their admissions, must give up the practice thereafter. Samuels and colleagues seem to have been especially unfortunate in their experience of babies with prolonged expiratory apnoea (blue breath holders). I am not aware of any deaths of babies with prolonged expiratory apnoea in Gwynedd although over 30 cases a year are seen in wards or outpatient clinics (the child population of Gwynedd is about 45 000 with 2800 births a year).

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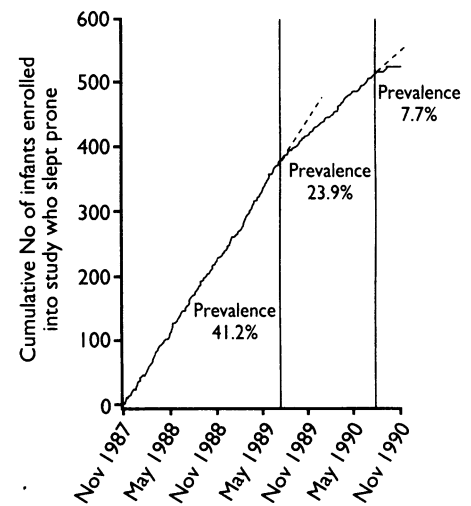
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Publicity and infants' sleeping position

EDITOR,—The rate of the sudden infant death syndrome in Scotland fell before the national campaign aimed at reducing the prevalence of the prone sleeping position.¹ A survey in Scotland found that 87% of health visitors had changed the advice given to parents about the syndrome and that 54% stated that this change occurred before mid-1991.² This preceded the national campaign in the United Kingdom, which began in November 1991. Furthermore, these health visitors cited journal articles and the mass media as the most important influences for changing advice. Data from the New Zealand cot death study show that the prevalence of the prone sleeping position decreased before the campaign in New Zealand and suggest that other publicity, such as that generated by fundraising campaigns, may have had an influence.

The New Zealand cot death study was a nationwide case-control study carried out from 1 November 1987 to 31 October 1990. Altogether 1800 control infants were randomly selected from all births in the study regions. The figure shows the cumulative number of these infants placed to sleep prone. The prevalence of the prone sleeping position was relatively constant at 41% until August 1990, was 24% for the next 12 months, and was about 8% for the final three months of the study. The two changes in infant care practice had a temporal relation with mass publicity accompanying fund raising for the Cot Death Association.

The association's first "Red Nose Day," in September 1989, emphasised the size of the problem and the devastating effect on parents. The fundraising part of the campaign was accompanied by items on television, in magazines, and on radio. Some of these would have included the suggestion that sleeping prone might not be safe for babies.



Prevalence of prone sleeping position among subjects enrolled into study. Vertical lines indicate times when prevalence of prone sleeping position changed; broken lines indicate prevalence before the changes

By 1990 unpublished data from the New Zealand study confirmed the increased risk of the sudden infant death syndrome if an infant was placed to sleep prone. In July 1990 a television advertisement by the Cot Death Association advised against placing infants to sleep prone. Publicity for its 1990 Red Nose Day in mid-August used television, radio, popular magazines, newspapers, and pamphlets to spread messages about reducing the risks, particularly "sleep baby on the side."

The wide publicity surrounding these two Red Nose Days and the change in the prevalence of the prone sleeping position preceded the national cot death prevention programme, which was formally launched in February 1991.³ The change in the prevalence of the prone sleeping position has been associated with a 40% fall in the rate of the sudden infant death syndrome in New Zealand.⁴ This analysis illustrates the potential health educational value of mass publicity surrounding fundraising activities.

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Mothers' consent to screening newborn babies for disease

EDITOR,—Neonatal screening for Duchenne muscular dystrophy has been introduced in Wales with close monitoring, social evaluation, and a continuing education programme.¹ This should result in uptake of the test being based on informed consent. Once a test becomes routine, however, the same care is unlikely to be taken. Even in this demonstration project one of the nine families with a positive diagnosis apparently entered the programme in ignorance. Routine Guthrie testing has