with the medical needs of the child and carers without the barrier of due processes. The late Dr Leonard Arthur and colleagues in Derby pioneered such an arrangement 30 years ago. The rest is a matter for local authority social services and the criminal justice system.

I am aware of the deplorable state of child public health statistics (some of which have not improved during the century of community paediatrics, in sharp contrast to the spectacular successes of individual child ill health statistics: take the survival from acute leukaemia as an example). But is this a responsibility for clinical paediatrics? Should not these and other population burdens that community paediatricians have assumed or had thrust upon them be returned where they belong: primary care, public health services, politicians (local and national)—and the Treasury.

I conclude that paediatrics, in or out of the community, is not dying: it may need more an apothecary's restorative than resuscitation. Nearly 20 years ago a thoughtful Bristol psychiatrist wrote a paper[1] entitled ''What should psychiatrists be doing in the 1990s?'', speculating how colleagues might adapt to change: running down of mental hospitals and the psychiatrist's place in the developing community based multidisciplinary mental heath teams. He concluded ''Keep up with your general medicine and be more open about yourselves''. Not a bad prescription for paediatricians either, nor for the specialty I love still.

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IMAGES IN PAEDIATRICS

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Intra-cardiac Burkitt's lymphoma

A 9 year old boy presented to our paediatric emergency department with a three week history of breathlessness, generalised body swelling, and an abdominal mass (fig 1). On examination he had signs consistent with right heart failure and a smooth, non-tender epigastric mass separate from his liver. Ultrasound examination of the abdomen suggested this mass to be nodal Burkitt's lymphoma, which was later confirmed by histology. Echocardiography revealed a 3.94 cm diameter mobile solitary intra-cavitary homogeneous mass, which appeared to be arising from the postero-medial wall of the right atrium, and prolapsing in and out of the right ventricle in addition to a global moderately sized pericardial effusion (fig 2). The mass impaired right ventricular diastolic filling and right ventricular outflow tract ejection.

Clinical improvement was rapid and dramatic following chemotherapy for Burkitt's lymphoma (fig 3). Repeat echocardiography four weeks after initial presentation showed the intracardiac mass had become much smaller and was no longer impairing right ventricular haemodynamics (fig 4). Our patient had been referred to us as a case of congestive cardiac failure, which is common in sub-Saharan Africa and often secondary to rheumatic heart disease, where symptomatic control with diuretic therapy is the mainstay of treatment. Diuretic therapy in our patient could have worsened his symptoms and caused a delay to diagnosis. Although a rarity outside Africa, Burkitt's lymphoma is the most common childhood malignancy in sub-Saharan Africa. Early recognition of its varied presentation is essential if avoidable morbidity and mortality is to be prevented.

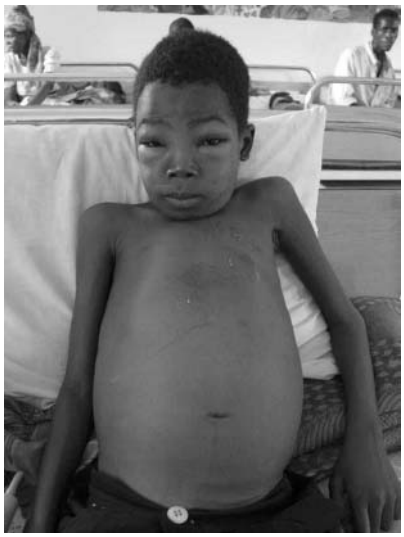

Figure 1

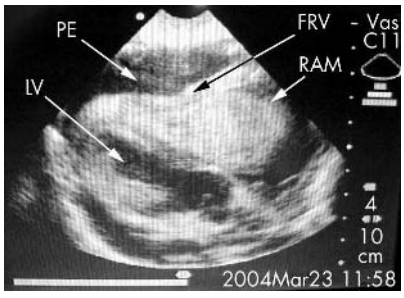

Figure 2 FRV, free right ventricular border; PE, pericardial effusion; RAM, right atrial mass; LV, left ventricle.

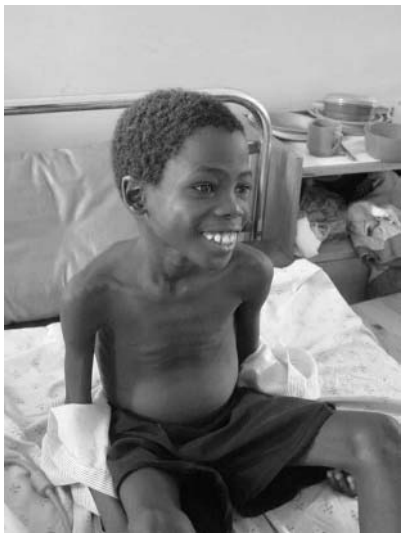

Figure 3

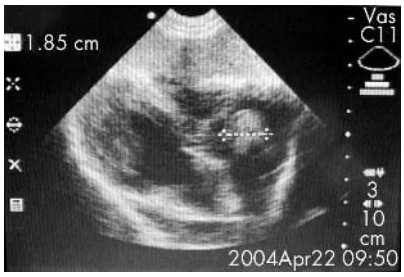

Figure 4

Consent was obtained for publication of figures 1 and 3.

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