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## LEADING ARTICLES

Cimetidine for ever (and ever and ever ...)?	1435	Respiratory complications of rheumatoid disease	1437
Hazards of epilepsy	1436	Sickle-cell anaemia in infancy	1439
Epidemic myalgic encephalomyelitis	1436	Social class, occupation, life, and death	1440
"How long will it last, doctor?"	1438		

## PAPERS AND ORIGINALS

Prevalence of retinopathy in a diabetic clinic	RICHARD J DONOVAN	1441
Phagocytosis and killing of bacteria and yeast by human milk cells after opsonisation in aqueous phase of milk	J E ROBINSON, B A M HARVEY, J F SOOTHILL	1443
Plasma arginine vasopressin concentrations and antidiuretic action of carbamazepine	W P STEPHENS, J Y COE, P H BAYLIS	1445
Haemophilia A home therapy in the United Kingdom 1975-6	PETER JONES, MAUREEN FEARNES, CHARLES FORBES, JOHN STUART	1447
Circulating immune complexes in pre-eclampsia	G M STIRRAT, C W G REDMAN, R J LEVINSKY	1450
Comparison of the tine and Mantoux tuberculin tests	J A LUNN, A J JOHNSON	1451
Evidence for intestinal origin of transcobalamin II during vitamin B <sub>12</sub> absorption	I CHANARIN, M MUIR, A HUGHES, A V HOFFBRAND	1453
Bone marrow aspiration for chromosome analysis in newborn	BRENDA M PAGE, J B S COULTER	1455
Ventilatory function in Parkinson's disease	A D MEHTA, W B WRIGHT, BRIAN J KIRBY	1456
Acute renal failure due to polymyositis	MARION F SLOAN, A J FRANKS, K A EXLEY, A M DAVISON	1457
Long-term self-administered subcutaneous heparin in pregnancy	GRAHAM SPEARING, IAN FRASER, GILLIAN TURNER, GEOFFREY DIXON	1457
Correction: Severe envenomation from "harmless" pet snake	MATHER	1458

## MEDICAL PRACTICE

Ileostomy or ileorectal anastomosis for ulcerative colitis?	PETER F JONES, P GILROY BEVAN, PETER R HAWLEY	1459
Cost of carrying out clinical diagnostic tests	D J BARNARD, J P BINGLE, C J GARRATT	1463
Committee on the Review of Medicines		1466
Letter from Chicago: Oblomov's syndrome	GEORGE DUNEA	1467
If I had hypertension	EOIN O'BRIEN	1469
Cardiac signs for students: the wheat and the chaff	JAMES K FINLAYSON, ALASDAIR C F KENMURE, DAVID S SHORT	1471
Medicine and Books		1474
Any Questions?		1465, 1473
Material Non Medica—Contributions from C I. DAVIDSON, JOHN TURNER, SHIRLEY FISHER		1479
Personal View	SHELAGH TYRRELL	1480

CORRESPONDENCE—List of Contents	1481
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## NEWS AND NOTES

Views	1492
Parliament—Nandicelle and multiple sclerosis	1493
Medical News	1493
BMA Notices	1494

OBITUARY	1495
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## SUPPLEMENT

The Week	1497
Parliamentary accountability and the NHS: need for separate committee	RUDOLF KLEIN 1498
Burden of administration	
Welsh devolution	

## CORRESPONDENCE

<b>Migraine in childhood</b> M A Salmon, FRCPED, and others.....	1481	<b>Coronary heart disease and male sex hormones</b> Ingrid L Waldron, PHD.....	1485	<b>Pituitary tumours and pregnancy</b> K W Hancock, MRCOG, and others.....	1487
<b>Routine procedures in general anaesthesia</b> G C Steel, FFARCS.....	1481	<b>Cetiprin (emeprium bromide) in patients with prostatism</b> E S Glen, FRCS; A D Lauder, MB.....	1485	<b>Factors influencing the incidence of neonatal jaundice</b> B S B Wood, FRCP.....	1488
<b>Standards for surgical therapeutic trials</b> D H Spodick, MD, and others.....	1482	<b>Stricture of oesophagus associated with ankylosing spondylitis</b> A P Weetman, MB.....	1485	<b>Myelography and lumbar venography</b> R G Grainger, FRCP, FRCR.....	1488
<b>Uniform style for biomedical journals</b> K G M M Alberti, MRCPATH; R Hole, FRCS	1482	<b>Is pancreatic isotope scanning worth while?</b> P B Cotton, FRCP.....	1485	<b>Pilots' hearts</b> J H McKillop, MRCGP, and others.....	1488
<b>Interrelated factors in hypertensive patients</b> V M Hawthorne, FRCPGLAS, and Mary Smalls, BSC; J H Fuller, MRCGP, and others..	1483	<b>Psychiatric problems after mastectomy</b> H G Kinnell, MRCPsych.....	1486	<b>Surgery for intermittent claudication</b> C V Ruckley, FRCS.....	1489
<b>The Stomach Cancer Group</b> P F M Wrigley, MRCGP, and V S Brookes, FRCS.....	1483	<b>Cimetidine and protective effect of mucus in gastric ulcer</b> M Guslandi, MD, and others.....	1486	<b>Umbilical cord prolapse</b> T Vago, MD.....	1489
<b>Television medicine</b> J Apley, FRCP.....	1483	<b>Painful young bellies</b> I H J Bourne, FRCP; H A Goudarzi, FRCS	1486	<b>Cough mixtures</b> D Adler, MRCs.....	1489
<b>Treatment of tuberculosis</b> A Seaton, FRCP.....	1484	<b>"Innovation in the Pharmaceutical Industry"</b> J F Cavalla, PHD.....	1486	<b>A British "Doctors' Ten"</b> R C Goodfellow, MB.....	1489
<b>Diuretics in the elderly</b> S Waldek, MRCGP; D M Burley, MRCGP....	1484	<b>Plasmapheresis</b> Daisy Obeid, MB, and Paula Cotter, MD..	1486	<b>Shortage specialties</b> J L C Dall, FRCPGLAS.....	1489
<b>Sulphinpyrazone after myocardial infarction</b> S H Kane, MD.....	1484	<b>Vincristine-induced neuropathy in lymphomas</b> Sylvia M Watkins, DM, and J P Griffin, PHD, MB.....	1487	<b>BMA and the Abortion Act</b> D C Flint.....	1490
<b>Plasma urate changes in pre-eclampsia</b> C W G Redman, MRCGP, and J Bonnar, FRCOG.....	1484	<b>Geriatric beds</b> R L G Sutcliffe, FRCPED.....	1487	<b>New consultant contract</b> P W Fisher, FRCP; G Johns, FFARCS; A E Carter, FRCS.....	1490
<b>Rubella vaccination</b> Leonora A Crawford, MFCM.....	1485	<b>Ultrasound and work load in the radiology department</b> B M Gompels, FRCR.....	1487	<b>Setting an example</b> J S Elkington, FRCS, and Gillian Elkington	1491

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

## Migraine in childhood

SIR,—The frequency of childhood migraine is poorly appreciated in many paediatric textbooks, so we the undersigned, who are concerned at the lack of understanding of migraine in children, have been discussing the topic at two meetings organised by the British Migraine Association. We would like to draw the attention of our colleagues to our conclusions and open the subject to discussion.

In 1962 the Ad Hoc Committee on Classification of Headache<sup>1</sup> defined migraine as "Recurrent attacks of headache, widely varied in intensity, frequency and duration. The attacks are commonly unilateral in onset; are usually associated with anorexia and, sometimes, with nausea and vomiting; in some are preceded by, or associated with, conspicuous sensory, motor and mood disturbances; and are often familial." This definition is widely accepted. It is, however, founded on presentations of migraine in adults, and does not cover certain aspects of the condition as it presents in children.

We found migraine in childhood difficult to define. It may present from early infancy on, and under the age of 10 has an equal sex incidence. All known types occur, classical

and common migraine being the most frequent presentations. Migraine of so-called basilar, hemiplegic, and ophthalmoplegic type can also be recognised from infancy onwards.

Typically, migraine attacks in childhood have an acute onset with headache, commonly frontal, accompanied by some of the following features: nausea with or without vomiting, anorexia, malaise, pallor, and a desire to sleep. Less commonly there may be eye pain, profound lethargy with or without hypotonia, sensory (commonly visual), motor, or mood disturbance, ketosis, and pyrexia. Attacks are usually over within 24 h, but episodes may cluster. In some children headache may be insignificant and the systemic upset predominant; such cases are not always readily diagnosed or accepted as migraine.

There are various symptom complexes which may be associated with migraine in childhood, although the validity of the relationship is not clearly established. These include: (a) Recurrent abdominal pain—colicky or epigastric aching; the pain is short-lived and central and may be accompanied by abdominal distension, nausea, and vomiting; the vomiting may be biliary, and lead to ketosis and de-

hydration (cyclical vomiting). (b) Episodic malaise, with anorexia, pallor, fever, and pale stools.

Our studies of this subject are continuing and we would appreciate observations.

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<sup>1</sup> Friedman, A P, et al, *Archives of Neurology*, 1962, 6, 73.

## Routine procedures in general anaesthesia

SIR,—I am grateful to those who have commented on my Personal View (22 April, p 1049) both through your columns and in personal letters: in the latter case I am particularly grateful for the kind comments that have been made.

Dr M A Thompson's pleasantly temperate letter (13 May, p 1275) suggests that my communication illustrates the changes between anaesthesia as it used to be and as it is now, which may well be the case. This change, if I interpret his letter correctly, is exemplified by the increased use of relaxants and of the endotracheal tube in cases in which the latter is not necessarily essential to the maintenance of a good airway. Up to the time of my