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CORRESPONDENCE

Correspondents are asked to be brief

Severely Malformed Children

SIR,—It is necessary to comment on Mr. R. B. Zachary's interpretation (26 May, p. 482) of the tape recorded discussion on severely malformed infants (5 May, p. 284). There is no "strange anomaly," as Mr. Zachary asserts, in the fact that though untreated babies with spina bifida in first-class centres have all died within a few months, surgeons and paediatricians "are seeing a number of untreated cases for salvage from other hospitals." The vital omission from Mr. Zachary's comment is that the "100% success" rate of no-treatment policy relates to those infants *selected* for no treatment because of the severity of their condition and not to *all* babies born with spina bifida. Since I advocated certain definite and strict criteria for selection[1] this policy has been largely accepted in Britain and in most other countries.

Between May 1971 and January 1973, 38 newborn infants have been referred to me, and of these 25 were not treated. All died within eight months (18 before three months of age); 12 of the 13 treated are alive and only one is badly handicapped. We were certainly and rightly horrified to see a few untreated older children who had gross and unnecessarily gross handicaps. These were usually those whose condition at birth was more favourable and who should have been treated, with a good chance of an acceptable quality of life. It is my conviction that all infants born with spina bifida should immediately be seen by an expert in this field, who, on the basis of his experience and with full explanation to the parents, should make the recommendation to treat or not. Occasional mistakes will be made, but if the initial assessment is correct, then the rare survivor in the non-treated group will not suffer if subsequently he is given the "total care" which those treated from the first day should normally receive.

It is very unfair to point to the occasional tragedy of a severely affected untreated infant without mentioning that for every one of these we have some 40 just as severely handicapped, with mental retardation, gross paralysis, incontinence, kyphos, and other handicaps, in spite of all the operations and other forms of therapy they had from a few hours of age onwards, from the days when we offered treatment to all infants irrespective of their condition at birth.[2]—I am, etc.,

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1 Lorber, J., *Developmental Medicine and Child Neurology*, 1971, **13**, 279.
2 Lorber, J., *Archives of Disease in Childhood*, 1972, **47**, 854.

Antibiotic-sensitivity Tests

SIR,—During trials by the Public Health Laboratory Service Quality-control Committee, which includes some members from N.H.S. hospital laboratories, the results of antibiotic-sensitivity tests have been studied in relation to the methods used. These studies are continuing, but directors of laboratories who cannot at present be accommodated in the scheme may wish to know of two significant results that have so far emerged.

Cephalosporin-sensitivity Test. A strain of *Staphyloccus aureus*, resistant to methicillin, was tested by disc diffusion methods for sensitivity to cephaloridine in 20 laboratories. Ten laboratories reported it sensitive and 10 reported it resistant, confirming the difficulty of testing sensitivity of staphylococci to cephalosporins by the disc method. Disc diffusion tests of cephalosporins against staphylococci may result in misleading reports being sent to clinicians, and the committee recommends that such tests should not be used for determining the sensitivity of staphylococci to this group of drugs. In practice it can be assumed that all methicillin-resistant strains of *Staph. aureus* are resistant to cephalosporins and that all methicillin-sensitive strains are sensitive to cephalosporins.

Ampicillin Content of Discs. High-content discs are often used for tests of urinary pathogens because high concentrations of ampicillin can be attained in urine. At present we have no comments to make on the validity of this practice. But when high-content ampicillin discs are used for testing pathogens from sites other than the urinary tract misleading reports may be issued, as shown by the following results from recent trials:

There is no statistically significant difference between our results with 2-μg and 10-μg discs for the *Bacteroides* nor between any of the discs for the *Proteus*, but 10 μg is probably the best compromise for use with most organisms from sites other than the urinary tract. When a 25-μg disc is used, diminished zone size indicating resistance may be recognized if it is compared with the zone of a fully sensitive control organism but the difference in zone size is likely to be more obvious with a 10-μg disc. The committee recommends, therefore, that discs containing 10-μg of ampicillin should be used

Ampicillin content of disc	Resistant *Bacteroides* Spp. (M.I.C. = 32 μg ml)			Sensitive *Proteus mirabilis**		
	No. of reports	Errors		No. of reports	Errors	
		No.	%		No.	%
2 μg	23	1	4	50	7	14
10 μg	14	1	7	36	3	8
25 μg	23	7	30†	57	1	2

*tested twice by most laboratories † P <0·05