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B O Olusanya, J K Renner and A A Okolo

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In an earlier report,¹ one of us drew attention to the plight of the many survivors of child mortality in the developing world and the lack of relevant data on developmental disabilities in the yearly report by UNICEF on the state of the world's children within the context of "health" as envisioned in the Alma Ata Declaration of 1978.² It is gratifying to note for the first time that UNICEF in its latest report³ has introduced data on 2–9-year-old children with seizure, cognitive, motor, visual or hearing disabilities. Although the data are sparse and based on parental accounts of a child's physical and mental development and functioning, it is nonetheless an important start towards addressing the needs of these children and improving the global database for developmental disabilities.

The addition of data on child discipline, whether psychological or physical punishment, also must be commended because of its close association with childhood disabilities. For instance, children with disabilities generally experience maltreatment more than children without disabilities.⁴ Those with communication problems, in particular, have a greater preponderance of first incidents from birth to 5 years than any other group of disabled children as their parents are more likely to resort to physical discipline often out of frustration and stress.⁴

Undoubtedly, more work is required on the epidemiology and to provide cost-effective interventions for disabilities in the first crucial years of life in the light of growing evidence associating countries such as Nigeria and India that account for the highest rates of neonatal, infant and child mortality with the highest proportion of developmentally disadvantaged children worldwide.⁵ It is therefore hoped that the renewed emphasis on under 5 mortality rate as "an indispensable measure of child health" or a "barometer of child well-being" will in due course give way to a measure that better reflects the vital but poorly understood links between child survival, disability and well-being in the developing world.

As financial and human resources are mobilised towards a two-thirds reduction in child mortality by 2015, we must not fail to acknowledge the need to ensure that no child is disadvantaged physically, mentally or socially. Health authorities at various levels in each country should be encouraged to build on these new initiatives by UNICEF as a fitting tribute to the Alma Ata Declaration as we celebrate its 30th anniversary this September (2008).

B O Oluasanya,^{1,2} J K Renner,³ A A Okolo⁴

¹ Institute of Child Health and Great Ormond Street Hospital for Children NHS Trust, University College London, London,

UK; ² Institute of Child Health and Primary Care, College of Medicine, University of Lagos, Lagos, Nigeria; ³ Department of Paediatrics, College of Medicine, University of Lagos and Lagos University Teaching Hospital, Idiaraba, Surulere, Lagos, Nigeria; ⁴ Institute of Child Health, College of Medical Sciences, University of Benin, Benin City, Nigeria

Correspondence to: Bolajoko O Oluasanya, Institute of Child Health and Great Ormond Street Hospital for Children NHS Trust, University College London, 30 Guilford Street, London WC1N 1EH, UK; b.olusanya@ich.ucl.ac.uk

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Resuscitate with the placental circulation intact

Reynolds,¹ in common with the majority of neonatologists and obstetricians, would be unable to keep his nerve and delay three minutes before clamping and cutting the cord to be able to proceed with resuscitation. However, maintaining a placental circulation may sometimes be all that is required as Aristotle² observed, "Frequently the child appears to be born dead, when it is feeble and when, before the tying of the cord, a flux of blood occurs into the cord and adjacent parts. Some nurses who have already acquired skill squeeze (the blood) back out of the cord (into the child's body) and at once the baby, who had previously been as if drained of blood, comes to life again".

We do not recommend the practice described by Aristotle but some lateral thinking is required. When reversal of tracheal occlusion, performed in cases of severe congenital diaphragmatic hernias, is needed at birth an ex utero intrapartum treatment (EXIT)³ procedure is used. Essentially a functional placental circulation is maintained until the tracheal occlusion can be removed and the neonate ventilated.

Resuscitation before the placental circulation has ceased allows some warm oxygenated blood to return to the neonate to supplement oxygenation from the newborn's lungs. Indeed as the pulmonary vasculature opens up, drawing blood from the rest of the body, the deficit is replaced by redistribution of the returning placental blood. This effect is recognised as the

placental transfusion that occurs in a physiological third stage.⁴

Resuscitation before the cord is clamped and cut takes a little preparation and thought. We have developed a procedure for use during a caesarean section to provide all the normal equipment for resuscitation without compromising the facilities for the neonate or the mother, so that ventilation and pulmonary respiration can be established while the cord remains intact.⁵ Precise arrangements may need to be modified according to different theatre layouts. Essentially it involves bringing the resuscitaire up to the side of the operating table. Other approaches are possible. Preparation and cooperation between obstetrician, paediatrician and theatre staff are the keys to success. There are likely to be substantial benefits for babies with significant hypoxia. When fetal distress is caused by cord compression such as with a nuchal cord, the fetus may already be hypovolaemic at birth. Delayed clamping allows time for the placental transfusion to correct the hypovolaemia.

D J R Hutchon, I Thakur

Memorial Hospital, Darlington, UK

Correspondence to: David J R Hutchon, Consultant obstetrician, Memorial Hospital, Darlington, DL3 6HX, UK; DJRHutchon@Postmaster.co.uk

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Pitfalls in the diagnosis and management of transient synovitis of the hip: a retrospective case-note analysis

Transient synovitis (TS) of the hip is a common cause of hip pain or gait abnormalities in young children (so-called "irritable hip"). Although TS can have a mild presentation, potentially devastating conditions such as septic arthritis (SA) need to be excluded. To improve our services, we performed a retrospective case-note analysis of children (<16 years old) who were presumptively diagnosed with TS between April 2003 and September 2007 at