whom were patients with breast carcinoma. A similar figure was reported in a study by Richards and McKissock,³ in which 16 of 22 long-term survivors remained well (only 10% of the patients subjected to craniotomy). Again, the best results were in patients with breast carcinoma.

Conclusion

Patients with supratentorial metastases have a better prognosis than those with infratentorial metastases. Among patients with infratentorial metastases, only those with breast carcinoma will occasionally benefit from neurosurgery. Among patients with supratentorial metastases, the only ones who are likely to benefit from neurosurgery, in terms of length and quality of survival, are those with breast carcinoma; some women with bronchial carcinoma; and an occasional patient with renal carcinoma.

The results of neurosurgery for an intracranial metastasis were not related to the interval between removal of a primary tumour and development of intracranial symptoms. Evidence of a previous primary tumour should not lead to the assumption that intracranial symptoms are due to a metastasis.

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General Practice Observed

Developmental surveillance in general practice

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Summary and conclusions

During a two-year study of a developmental surveillance programme covering all children under 5 in a large general practice in the south of England, 2157 children were examined, including 382 newborn babies seen at home. Suspected disorders—excluding those found during non-routine consultations—were discovered in 232 children (15% of boys and 11% of girls), of whom 171 (104 boys and 67 girls) were referred to specialist agencies.

The number and nature of the disorders show that routine surveillance on the lines proposed by the Court Committee is worth while. Nevertheless, such programmes could not be started on a national scale without increased resources for the specialist services to which more children would need to be referred.

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Introduction

In the United Kingdom paediatric care in general practice has been largely illness oriented. Some general practitioners, however, have anticipated the Court Report's proposals¹ in starting health care and surveillance programmes.²⁻⁴ During the last 10 years we have developed a surveillance programme for all the under-5s in our practice. This comprises immunisation and developmental guidance, a co-ordinated health visitor service, and a set of routine examinations including both a medical and a developmental component. In this paper we indicate the rate of suspected (not necessarily confirmed) abnormalities detected by our examinations, and discuss the implications for the work load of the specialist services. Such estimates are an essential preliminary to setting up any nationwide surveillance programme on the lines of the Court Report's recommendations.

Patients and methods

There are usually about 1100 children under 5 in our six-man practice of 18 500. The percentage of the population in each social class in the area covered by the practice (with national figures in parentheses) is: I—9 (5); II—16 (14); III—53 (54); IV—13 (17); V—5 (6).

The three doctors who take part spend four sessions a week (46 weeks a year) on the surveillance programme, excluding home visits to newborn babies. About three-quarters of the doctor's time in the clinic is spent on routine examinations and the rest on the more usual

clinical consultations. All three have extensive experience in child health. The routine examinations are carried out in the first three weeks of life in the home and at seven months, 12 months, 28-30 months, and four and a half years, with a selective examination at three years. All children under 5 newly registered with the practice are seen within a few weeks; "at risk until seen" is an axiom in our programme. We also see at our clinics children discharged in the neonatal period from the local hospital's paediatric department who would otherwise attend its at-risk follow-up clinics. Children are seen without an appointment between routine examinations if there are problems that cannot be dealt with by the health visitor.

The examinations have four main aims: to confirm normality; to offer developmental guidance and counselling; to pick up variations and deviations from the range of normal growth and development so that any disorders that could cause handicap can be diagnosed and treated by specialist agencies; and to follow up all children with abnormalities or with environments and handicaps that give cause for concern. Some children have a clear-cut disorder, but even if a disorder is only suspected by either doctor or parent this should often be reason enough for referring the child for specialist help.

The examination of newborn babies (about 200 a year) is carried out at home, mostly in the first 12 days. About 20-30 minutes is spent with each mother and child. Apart from the full conventional examination, special efforts are made to show the mother her baby's ability to see her face in focus at 20-26 cm⁵ and to respond to the human voice by turning to the source of the sound. She is also shown the phenomenon of "violation,"⁶ the baby's response to the cessation of speech with the mother's face in view, which can be demonstrated with practice in nearly every newborn baby (though few have described it in the newborn). This has a powerful effect on the mother, who clearly sees the implications for interaction with her child.^{7,8} Each mother is given enough time to discuss any problems, and the aims of the surveillance programme are explained. Parents often find it hard to believe that we are interested in their well children or that we might find anything wrong. About 70% of babies do not need to be seen again before the routine examination at seven months, but 30% are given an earlier appointment—for reasons such as low Apgar scores, weak face fixing and rapid violation, unrealistic attitudes or depression in the mother, and adverse home conditions.

Each doctor uses an identical technique of examination, the uniformity being of great value in assessment. The system we use was developed by the Ashford developmental paediatric research group (a working party associated with the Royal College of General Practitioners). The protocol requires an invariable routine of examination that prevents omissions. Each examination takes 11-18 (mean 14)

minutes. The results are recorded on the forms shown in the appendix. These fit inside the infant welfare card in wide use in Britain and when completed provide an accurate and convenient record of the child's growth and development.

We take great care to see that no child is missed out of the programme. The secretary (who works 10 hours a week and is paid by the Community Health Services) organises the clinics and records, and ensures that all children are seen, arranging for those who miss appointments to be followed up. A health visitor delivers the appointment card personally to parents who miss the first two clinic appointments. She welcomes this opportunity to meet the non-attender because she often comes on quite unsuspected problems, such as unregistered child minders, illness in the mother, and behaviour problems. Occasionally, if her visit fails to bring mother and child to the clinic, the doctor with whom the child is registered writes a personal letter. This almost invariably works.

We have assessed the results of the surveillance programme on the basis of examinations carried out in 1976-7.

Results

In the last two years we have carried out 2157 routine surveillance examinations. The total number of the varied disorders (or suspected disorders) detected during the five routine examinations was 232, 171 of the children being referred for specialist help (table I); this excludes disorders found during non-routine visits to the doctor. If speech delay (which is more common in boys) is excluded, 96 of the 905 boys (11%) and 69 of the 870 girls (8%) who were examined had suspected disorders. One hundred and four (11%) of the boys and 67 (8%) of the girls were referred to specialist agencies (table II).

TABLE II—Surveillance programme referrals to specialist agencies in two years

	No	Annual percentage*
Ophthalmology	59	3.0
Audiology	27	1.5
Speech therapy	54	2.7
General surgery	8	0.4
Developmental paediatric service	15	0.7
General paediatric service	3	0.15
Orthopaedic services	3	0.15
Social services	1	0.01

*Percentage of all children in the practice under 5 years.

TABLE I—Numbers of suspected disorders found over two years during the five routine surveillance examinations (numbers of referrals to specialist agencies in parentheses)

Age at examination:	7 m		12 m		28-30 m		3 y*		4½ y		Total	
No examined:	M 201	F 183	M 194	F 216	M 177	F 192	M 104	F 63	M 229	F 216	M 905	F 870
Defective colour vision	7 (7)	6 (6)	4 (4)	4 (4)	4 (4)	3 (3)		3 (3)	4†	2†	4	2
Strabismus	2 (2)		1 (1)	2 (2)	1 (1)	2 (2)		2 (2)	1 (1)	2 (2)	16	18
Myopia	4 (4)	2 (2)		1 (1)	8 (8)	6 (6)	1 (1)	1 (1)	8 (8)	7 (7)	12	13
Suspected hearing loss					13 (6)	7 (1)	20 (20)	9 (9)	3 (3)	1 (1)	16	11
Speech delay					1 (1)		1 (1)		10 (10)	8 (8)	43	24
Language delay											2	
Cerebral palsy			3 (3)	1 (1)						1 (1)	3	2
Hypotonia	1	1		1 (1)				1 (1)			2	2
Hypertonia	2	1									2	1
Motor delay	2 (1)	3 (1)		2							2	5
Developmental delay	1				2 (1)	1	4 (4)		1 (1)		8	1
Fine motor incoordination									3	2	3	2
Behaviour disturbance						1		2	1	2	1	5
Depression			1		3		1		3		8	
Battered baby			1 (1)						1		1	
Maternal deprivation	1		1 (1)						3		2	
Orthopaedic problems	3 (2)	2 (1)									3	2
Ectopic testes					1 (1)		1 (1)		4 (4)		6	
Hypospadias					1 (1)						1	
Balanitis requiring circumcision	1 (1)										1	
Obesity		2							1	1	1	3
Large head	1		1								2	
Heart murmur thought significant					1 (1)							1
Enlarged spleen							1				1	
Total No	25 (17)	17 (10)	12 (10)	11 (9)	34 (23)	21 (13)	29 (27)	18 (16)	39 (27)	26 (19)	140 (104)	92 (67)
% of No examined	12	9	6	5	19	11	28	29	17	12	15	11
% excluding speech delay	12	9	6	5	12	7	4	4	13	8	11	8
Grand total	42		23		55		47		65		232	

*Selective examination.

†Colour vision tested only in last six months of study.

The disorders we discovered in these examinations cover the entire range that can occur in normal development. The 12-month examinations detected the smallest number but were fully justified by the nature of the disorders found. Of the five children found to have cerebral palsy, the 4½-year-old girl was a recent arrival who had never previously attended a child health clinic. Her noticeable monoplegia had been attributed to clumsiness by her mother. The other four cases were diagnosed at 12 months, and only one of these children had earlier shown some increase in muscle tone and a low Apgar score that made the diagnosis likely; in one of the other cases, however, there had in retrospect been some pointer that might have predicted the later spasticity.

The rates of failure to keep appointments compared very favourably with those reported in other studies,^{9,15} and were much lower than those at community paediatric clinics in general.¹⁰ The overall failure rate was 15% for first appointments and 4% for two or more (table III); the highest rate was for the examination at 28-30 months, when 7% of the boys and 4% of the girls failed to keep two or more appointments. Social class has not appeared to affect appreciably the failure rate for first appointments but does make subsequent failures somewhat more likely. Families who are newly registered with the practice often fail to keep first appointments, despite an explanatory letter. The children in this group also have a suspected disorder rate appreciably higher than the rest—higher than could be explained simply by their lack of previous surveillance: mobility itself seems to be associated with high risk.¹¹

There is also a small but definite sex difference in attendance rates. In the first of the two years of the study nearly twice as many girls as boys missed their first appointment—a previously unreported difference. The often quoted (but statistically unconfirmed) saying "Mothers don't worry so much about their girls" has no justification if there is indeed no sex difference in the incidence of disorders other than speech delay.

Discussion

Efficiency in detecting abnormality is critically important in any surveillance programme. With a high false-positive rate the specialist diagnostic services are overwhelmed and parents made anxious unnecessarily; while with a high false-negative rate children reach school with disorders undiagnosed and therefore untreated.¹² An accurate and sensitive index of suspicion needs to be developed, and constant practice with the normal improves the diagnosis rate of disorders at the boundaries of abnormality. Surveillance must therefore be carried out by doctors trained to do it. To hive off some parts of the examination, such as tests of vision or hearing, is unrealistic: often the response to one test throws light on problems in a totally different body system or field of behaviour, and this applies particularly to vision and hearing tests. We have not therefore delegated any part of the examinations to other health visitors, nurses, or other professionals.

A single examination is often thought sufficient for detecting myopia, strabismus, or hearing loss. Our experience, and that of others,¹³ is totally at variance with this view. Myopia and strabismus may develop quite suddenly and are detected at all ages in children who have previously had meticulous examinations; moreover, amblyopia sometimes develops with great rapidity once a squint appears (and occasionally even without a squint).

Our experience with detecting hearing loss is disappointing because the standard Stycar tests give a high false-positive rate in our hands. Lacking sophisticated equipment, however, we are bound to refer all suspected cases to the audiology services.

Referral rates are inevitably governed by the availability of

specialist services. In parts of the country where there are no speech therapists, for example, speech delay cannot usefully be labelled as a disorder or the child referred for treatment. We can look for speech delay and refer children at an early age because our speech therapy service is adequately staffed. Our figures are probably much closer to the true rate of speech delay than are the figures from areas lacking treatment facilities.¹⁴ Some social services departments indeed operate only a crisis intervention service with a published scale of "urgencies." Children with eye disorders may be referred much too late or not at all—if, for example, there is no ophthalmologist for 40 miles who is interested in treating 7-month-old babies with strabismus or able to do accurate refraction on 1-year-olds. If there were referral rates similar to ours in other areas the number of orthoptists alone would need to be many times greater than at present.¹⁵

Our rate of referral from the surveillance clinic to general paediatric services, however, is extremely low. In fact, there is a low paediatric referral rate from the practice as a whole. But only half the children seen in hospital outpatient departments, it has been claimed, have anything wrong with them; the parents' anxieties that something is wrong bring the other half to hospital. Spending adequate time on examining the well child perhaps provides the needed reassurance in our practice. If the low referral rate is a result of the surveillance programme and such programmes become widespread there will be considerably less demand for hospital paediatric services.

Surveillance programmes like ours are running in many practices. In our experience the Court Committee's proposals¹ for general practitioners with paediatric interests are perfectly workable, GHCJ's paediatric work load being compatible with a large personal list of patients. Our experience has also shown how the community health services can work in close co-operation with general practice—though neither of our community health doctors would want to participate in the way envisaged in the Court Report, their skills and interests being of a different kind.

Much of the criticism of the Court Report's proposals has been based on misunderstanding of the general practitioner paediatrician's role¹⁶; many GPs, moreover, are not aware of what surveillance is.¹⁷ Our results show that paediatric surveillance is worth the effort. Nevertheless, such programmes could not be started on a national scale unless increased resources were provided for the specialist services to which more children would need to be referred.

I thank my partners for their help in this study, but in particular the health visitors Mrs W Richardson, Mrs R Sandicroft, Miss S Carville, and Mrs D Turner and my programme secretary Mrs D Darvell for their efforts in sustaining the programme. I also thank members of the developmental paediatric research group for permission to publish the schedules of examination and acknowledge their pioneer role in their development.

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TABLE III—Appointment failures at surveillance clinic in two years. Results are numbers (and percentages)

Age at examination:	7 m		12 m		20-30 m		3 y		4½ y		Mean of all examinations		
Sex: No:	M 201	F 183	M 194	F 216	M 177	F 192	M 104	F 63	M 229	F 216	M 905	F 870	Total 1775
Failed first appointments	20 (10)	18 (10)	16 (8)	26 (12)	29 (16)	29 (15)	17 (16)	18 (29)	35 (15)	47 (21)	117 (13)	138 (16)	255 (14)
Failed two or more appointments	5 (2)	3 (2)	9 (5)		13 (7)	7 (4)	2 (2)	1 (1)	3 (1)	8 (4)	32 (4)	19 (2)	51 (3)

Appendix

1		2		3		4		5		6	
Exam. within 21 days of Birth		Exam. at 7 months		Exam. at 12 months		Exam. at 24 months		Exam. at 36 months		Exam. at 54 months	
Date		Date		Date		Date		Date		Date	
Mother's Comments		Mother's Comments		Mother's Comments		Mother's Comments		Mother's Comments		Mother's Comments	
Happy		Happy		Happy		Happy		Happy		Happy	
Sleeps		Sleeps		Sleeps		Sleeps		Sleeps		Sleeps	
Eats		Eats		Eats		Eats		Eats		Eats	
Illness since last exam.		Illness since last exam.		Illness since last exam.		Illness since last exam.		Illness since last exam.		Illness since last exam.	
(If yes specify nature of illness)		(If yes specify nature of illness)		(If yes specify nature of illness)		(If yes specify nature of illness)		(If yes specify nature of illness)		(If yes specify nature of illness)	
Change in family circumstances		Change in family circumstances		Change in family circumstances		Change in family circumstances		Change in family circumstances		Change in family circumstances	
Play group		Play group		Play group		Play group		Play group		Play group	
Nursery		Nursery		Nursery		Nursery		Nursery		Nursery	
Minder		Minder		Minder		Minder		Minder		Minder	
Hours worked per week (Mother)		Hours worked per week (Mother)		Hours worked per week (Mother)		Hours worked per week (Mother)		Hours worked per week (Mother)		Hours worked per week (Mother)	
Breast Fed		Breast Fed		Breast Fed		Breast Fed		Breast Fed		Breast Fed	
Solids started		Solids started		Solids started		Solids started		Solids started		Solids started	
Birth WT.		Birth WT.		Birth WT.		Birth WT.		Birth WT.		Birth WT.	
Gms.		Gms.		Gms.		Gms.		Gms.		Gms.	
Maturity		Maturity		Maturity		Maturity		Maturity		Maturity	
Asym. Symm.		Asym. Symm.		Asym. Symm.		Asym. Symm.		Asym. Symm.		Asym. Symm.	
Moro Response		Moro Response		Moro Response		Moro Response		Moro Response		Moro Response	
Grasp		Grasp		Grasp		Grasp		Grasp		Grasp	
Walking		Walking		Walking		Walking		Walking		Walking	
Placing		Placing		Placing		Placing		Placing		Placing	
Sound Resp.		Sound Resp.		Sound Resp.		Sound Resp.		Sound Resp.		Sound Resp.	
Light Resp.		Light Resp.		Light Resp.		Light Resp.		Light Resp.		Light Resp.	
Ventral Susp.		Ventral Susp.		Ventral Susp.		Ventral Susp.		Ventral Susp.		Ventral Susp.	
PHYSICAL EXAMINATION		PHYSICAL EXAMINATION		PHYSICAL EXAMINATION		PHYSICAL EXAMINATION		PHYSICAL EXAMINATION		PHYSICAL EXAMINATION	
Weight		Weight		Weight		Weight		Weight		Weight	
Height		Height		Height		Height		Height		Height	
H.C.		H.C.		H.C.		H.C.		H.C.		H.C.	
Norm.		Norm.		Norm.		Norm.		Norm.		Norm.	
State Abnormalities		State Abnormalities		State Abnormalities		State Abnormalities		State Abnormalities		State Abnormalities	
Skull		Skull		Skull		Skull		Skull		Skull	
Ears		Ears		Ears		Ears		Ears		Ears	
Eyes		Eyes		Eyes		Eyes		Eyes		Eyes	
Palate		Palate		Palate		Palate		Palate		Palate	
C.V.S.		C.V.S.		C.V.S.		C.V.S.		C.V.S.		C.V.S.	
R.S.		R.S.		R.S.		R.S.		R.S.		R.S.	
Abdo.		Abdo.		Abdo.		Abdo.		Abdo.		Abdo.	
Spine		Spine		Spine		Spine		Spine		Spine	
Hernia		Hernia		Hernia		Hernia		Hernia		Hernia	
Fem. Pulses		Fem. Pulses		Fem. Pulses		Fem. Pulses		Fem. Pulses		Fem. Pulses	
Genitalia		Genitalia		Genitalia		Genitalia		Genitalia		Genitalia	
Hips		Hips		Hips		Hips		Hips		Hips	
Limbs		Limbs		Limbs		Limbs		Limbs		Limbs	
Tone		Tone		Tone		Tone		Tone		Tone	
Reflexes		Reflexes		Reflexes		Reflexes		Reflexes		Reflexes	
Skin		Skin		Skin		Skin		Skin		Skin	
Biochem		Biochem		Biochem		Biochem		Biochem		Biochem	
Appearance		Appearance		Appearance		Appearance		Appearance		Appearance	
Comments		Comments		Comments		Comments		Comments		Comments	
Action		Action		Action		Action		Action		Action	
If tests incomplete because of child's unco-operation put tick in box		If tests incomplete because of child's unco-operation put tick in box		If tests incomplete because of child's unco-operation put tick in box		If tests incomplete because of child's unco-operation put tick in box		If tests incomplete because of child's unco-operation put tick in box		If tests incomplete because of child's unco-operation put tick in box	

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WORDS The Erzgebirge (ore mountains) are a 90-mile-long range stretching along the north-western frontier of Bohemia in Czechoslovakia, where it adjoins Saxony in East Germany. It is an area famous for its health resorts and for the mining of various metallic ores. On the Bohemian side lies the Joachimsthal (Joachim's Dale). I suppose everyone knows of the high mortality from bronchial carcinoma affecting miners in the Joachimsthal, which is attributed to the inhalation of radioactive particles, possibly aggravated by traces of arsenic. But did you know that the American dollar was named after the joachimsthaler? This was the standard German monetary unit for 350 years until superseded by the mark in 1873, and was so called because it was minted from silver mined in the Joachimsthal. Joachimsthaler was too long a word, even for Germans; it was shortened to thaler (pronounced tahler), whence the word dollar (pronounced dahler) derives.