admitted to the paediatric ward, representing 3.8% (17/439) of the infants under 1 year but 12% of the bed occupancy.

Infants who had previously been in the neonatal intensive care unit accounted for a large proportion of the bed occupancy partly because they stayed in the ward longer for general problems (such as upper respiratory infections and social and feeding difficulties) than the other infants (table) and partly because a small number needed prolonged admissions for intensive treatment of chronic conditions—for example, one infant with chronic lung disease needed ventilation for five months and another required many months of intravenous feeding after extensive bowel resection in the neonatal period.

Comment

Although only a small number of infants who had previously received intensive care required admission to the paediatric ward, they represented about half the bed occupancy of infants under 1 year. Interestingly, although the paediatric ward served only the Cambridge Area Health Authority, babies admitted to the neonatal intensive care unit from the region accounted for about one third of the bed occupancy of those aged under 1 year.

This study highlights the need for continued intensive nursing care for a few infants under 1 year after their discharge from a neonatal intensive care unit. This represents a considerable workload for a general ward, and as the survival rates of such infants continue to improve⁴ it is vital that these wards should be appropriately staffed and equipped.

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(Accepted 19 April 1985)

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Spontaneous urinoma due to retroperitoneal fibrosis and aortic aneurysm

Rupture of the ureter or renal pelvis leading to a mass of encapsulated extravasated urine usually occurs after surgery or trauma. When it occurs spontaneously it is usually a result of ureteric obstruction due to calculus. We report a case of urinoma caused by retroperitoneal fibrosis in association with an aortic aneurysm.

Case report

A 72 year old man with a history of right ureterolithotomy was admitted for investigation of uraemia. He was found to have a large, firm, ballotable abdominal mass on the left side. Blood urea concentration was 20.2 mmol/l (121 mg/100 ml) and creatinine concentration 428 µmol/l (4.8 mg/100 ml). Intravenous urography showed a small right kidney and a hydronephrotic left kidney displaced upwards by a mass. The left ureter was not identified. Ultrasonography showed an abdominal aortic aneurysm with a large cystic mass adjacent. After needle aspiration had confirmed that this mass contained urine, contrast was injected (figure) and 600 ml fluid aspirated. Retrograde urography confirmed the presence of high ureteric obstruction, and at operation a urinoma above a 2.5 cm segment of necrotic ureter was found. There was dense fibrosis around the aneurysm and the ureter. A nephrostomy tube was inserted, the necrotic ureter excised, and an end to end ureteric anastomosis fashioned over a Cummings tube. After surgery he had a diuresis via the nephrostomy and his blood urea concentration fell to normal.

Comment

Urinomas may result from trauma to the ureter or renal pelvis, ureteric obstruction from calculus, neoplasm, tuberculosis, or

rarely, disease of the spinal cord.^{1,2} Urinoma complicating renal papillary necrosis in an elderly diabetic was recently described.³ Although retroperitoneal fibrosis associated with aortic aneurysm may occasionally result in ureteric obstruction,⁴ we are not aware of

Result of percutaneous injection of contrast into large urinoma in left side of abdomen.

any previous reports of urinoma complicating either retroperitoneal fibrosis or aortic aneurysm. We believe that the pathogenesis of the urinoma in this case was ischaemic necrosis due to the infiltrative perianeurysmal fibrosis.

We thank Dr C L Hall and Mr C U Moisey for permission to report this case.

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(Accepted 29 April 1985)

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Care by parents in hospital

With the introduction of unrestricted visiting and the provision of accommodation parents are playing a larger part in caring for their children in hospital. In the United Kingdom the child is under the care of a medical and nursing team and parents assist if they can and are allowed to. Alternative facilities—"care by parent" units—have been evaluated to some extent in this country^{1,2} and more extensively abroad.³⁻⁵ Here, child and parent are admitted together; the daily care is given by parents, but nurses and medical staff help and perform those procedures requiring special knowledge or skill. Studies have indicated that these units are more economical, and that in them the child is less disturbed, the confidence and competence of parents are reinforced, and fewer nursing staff are required.^{3,4}

The role of parents depends on the extent to which they are able and willing to perform nursing procedures. We report what parents considered they were able to do.

Methods and results

Parents of 80 of the 112 children admitted to an acute medical ward at this centre from 3 September to 7 October 1983 were interviewed. The parents of the 32 other children did not appear to differ from those interviewed with respect to social class distribution, number of other children, ICD classification of the child's disease, etc.

Tasks that parents performed compared with what they thought they could do and what the staff thought they could do

Tasks	No (%) of parents who had performed procedure alone (n = 80)	No (%) of parents who had performed procedure plus those who thought they would be capable of doing so (n = 80)	No (%) of staff members who considered an "average" parent capable of performing procedure (n = 54)
Bottle feed infant	57 (71)	78 (98)	53 (98)
Change nappies	71 (89)	79 (99)	52 (96)
Bath child	67 (84)	80 (100)	52 (96)
Comfort child	77 (96)	80 (100)	51 (94)
Feed child	59 (74)	78 (98)	51 (94)
Entertain child	69 (86)	77 (96)	51 (94)
Undress child on admission	67 (84)	77 (96)	50 (93)
Encourage child to drink fluids	63 (79)	77 (96)	37 (69)
Hold child for doctor's examination	67 (84)	79 (99)	36 (67)
Keep record of food and fluid intakes	29 (36)	74 (93)	29 (54)
Put child on bedpan	21 (26)	75 (94)	29 (54)
Empty bedpan	16 (20)	78 (98)	29 (54)
Go with child to x ray department	42 (53)	68 (85)	28 (52)
Change bed linen	27 (34)	68 (85)	24 (44)
Keep record of amount of urine passed and bowel movements	24 (30)	58 (73)	22 (41)
Obtain urine specimens	29 (36)	61 (76)	20 (37)
Feed and bath child with intravenous fluids running	14 (18)	43 (54)	13 (24)
Take temperature	21 (26)	58 (73)	12 (22)
Feed and bath child in oxygen tent	3 (4)	24 (30)	12 (22)
Give pills or liquid medicine	41 (51)	64 (80)	11 (20)
Remain with child during painful procedure	41 (51)	52 (65)	9 (17)
Observe respirations for reporting to nurse	7 (9)	41 (51)	8 (15)
Take pulse for reporting to nurse	2 (3)	38 (48)	5 (9)
Go with child to theatre	7 (9)	43 (54)	4 (7)
Return with child from theatre	5 (6)	57 (71)	2 (4)
Change dressing	5 (6)	34 (43)	2 (4)
Restrain child for painful procedure	29 (36)	39 (49)	2 (4)
Give injections	1 (1)	8 (10)	1 (2)
Give enema	1 (1)	13 (16)	1 (2)
Watch rate of infusion of intravenous fluids	6 (8)	37 (46)	1 (2)
Take blood pressure	1 (1)	24 (30)	0

Parents were given a list of nursing procedures prepared by the General Nursing Council and asked whether they had performed them or believed that they could do so. A description of a care by parent unit^{4,5} was then read to them and their views recorded. In particular they were asked whether, given the opportunity, they would have preferred their child to be admitted to such a unit. All paediatric nursing staff and senior house officers at the centre were asked whether they thought the "average" parent could perform the procedures listed; 54 of 67 replied.

In 48 of 80 cases one parent (the mother in 47 cases) stayed with the child throughout his stay in hospital. In most instances the paediatric staff thought that parents could do more than they did, but parents thought that they could do even more than the staff thought. Forty eight parents said that they would have used a care by parent unit had one been available.

Comment

Over the past 10 years in Nottingham an attempt has been made to encourage parents to stay with their children. If this sample is representative of parents as a whole then important changes might be expected in children's wards. Altogether 60% of children had one parent with them throughout their stay, which means that for every three children in the ward there were two parents who needed overnight accommodation.

What parents do while they are with their child depends on the nature of their child's illness. Their main task might be considered to be to comfort and entertain, but the questionnaire shows that they are prepared to do far more. At present, the responsibility for many of these tasks lies with the ward team. Parents may be reluctant to interfere and are often unaware of what is happening, but if the

present trend continues they will inevitably be better informed and wish to play a greater part. Nevertheless, their main role will continue to be a supportive one.

For some families, and in some of the conditions for which children are admitted to hospital, it may be more satisfactory and effective if parents remain responsible for their child. The appropriate facility would be a care by parent unit, which could be a separate ward or section of a ward; this concept has already been tried and tested by far sighted paediatricians. Such a service requires careful planning and evaluation; nevertheless, it is the logical development of our current practice.

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(Accepted 2 May 1985)

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Randomised trial of antivenom in snake envenomation with prolonged clotting time

Antivenom is the mainstay of treatment of envenomation by snakes. Despite its widespread use recommendations on the dose and frequency of administration are vague.^{1,2} No clinical trials have been conducted to determine the ideal dose.³ We compared the response of patients receiving full doses of antivenom with another group receiving half the dose.

Patients, methods, and results

All patients who gave a history of snakebite and had evidence of fang marks, whose clotting time (Lee and White method) was over 15 minutes on admission, and who had not received any antivenom were studied. Patients were randomly allotted to one of the two treatment groups. Antivenom was given by titrating the dose against the effect of venom—that is, against the clotting time. Clotting time was measured after one and two hours and then every three hours until it became normal.

Patients in group 1 received four ampoules of antivenom in the first hour, four in the next two hours, four in the next three hours, and three every subsequent three hours. Patients in group 2 received two ampoules of antivenom in the first hour, two in the next two hours, and two every subsequent three hours. Infusion of antivenom according to the above protocol was stopped when the clotting time became normal (under 10 minutes). After the clotting time had returned to normal two or three ampoules of antivenom were added to 500 ml 5% glucose and infused over 24 hours to neutralise any further venom that might be absorbed. If the clotting time returned to normal at the

Effect of antivenom on patients suffering from snakebite

	Group 1*	Group 2*
No of patients	26	27
Mean dose of antivenom (ampoules)	15.3	7.9
Mean delay in starting treatment	4 h	6 h
Mean time for clotting time to normalise	42 min	9
	10 h	
	23 min	
No of patients with acute renal failure	5	6
No of patients who underwent dialysis:		
Peritoneal dialysis	2	
Haemodialysis	1	2
No of deaths	1	1
Other complications:		
Iridocyclitis		1
Retinal artery spasm	1	
Peripheral circulatory failure		1
Non-healing ulcer		1

*For protocol see text.