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 alone 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.

end of 12 hours the patient received 18 ampoules of antivenom if in group 1 and 10 ampoules if in group 2. Lyophilised polyvalent antivenom (Haffkine Biopharmaceutical Corporation, Bombay) was used throughout. The dose of antivenom was dissolved in distilled water and then added to 100-300 ml 5% glucose for infusion. Children and adults were given the same dose.

Comparison of the two groups was based on the interval between administration of the first dose of antivenom and the first normal clotting time and on the number of patients developing complications. For the purpose of the study acute renal failure was defined as oliguria for 24 hours (urine output below 400 ml) or more with raised blood urea or serum creatinine concentrations.

The study was conducted between July 1982 and June 1983 and included 53 patients. The interval between the patient being bitten and treatment being started, the period for the clotting time to become normal, and the number of patients who developed acute renal failure and other complications were not appreciably different between the two groups (table). None of the patients had any neurological deficit attributable to envenomation by cobra or krait. None were sensitive to antivenom on skin testing, and serum reactions to antivenom were transient and did not necessitate treatment being stopped.

Comment

The poisonous snakes in this area are cobra (*Naja naja*), common krait (*Bungarus caeruleus*), saw scaled viper (*Echis carinatus*), and Russell's viper (*Vipera russelli*). Viper bite causes disseminated intravascular coagulation and primary pathological fibrinolysis.⁴ Measurement of the clotting time is a readily available, simple, and inexpensive test for confirming envenomation by viper. Lyophilised antivenom is preferred to antivenom supplied in liquid form because it is more stable. Administration of antivenom by slow intravenous infusion is the preferred method, and doses should be given until the clotting time is normal. The dose recommended by the manufacturers is based on mouse protection studies and scaling the dose in proportion to the average yield of venom.³ In the absence of any definite recommendations, we and other clinicians have been using high doses.⁵ This study suggests that giving 7.9 ampoules of antivenom according to our protocol is as effective as using higher doses.

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(Accepted 19 April 1985)

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Prognosis of colonic Crohn's disease

To avoid bias in selecting patients it is necessary when assessing prognosis to study patients in whom the diagnosis was made soon after the onset of symptoms. We report the prognosis of all 57 patients with Crohn's disease predominantly affecting the large bowel seen within six months of the onset of symptoms during 1969-78 and followed up until 1984. Six patients with a previous anal lesion were excluded.

Patients, methods, and results

Colonic Crohn's disease was diagnosed using a scoring system¹; typical granulomas were found in 38 patients. The disease was rectal in six cases, rectal and colonic in 35, and colonic only in 16. The terminal ileum was affected in six patients, and an anal lesion was found at presentation or later in 42 patients. Twenty two patients were aged less than 30 and 20 were 60 or over.

In all but two patients the initial treatment was medical. Twenty patients required bowel surgery, 10 within a year of first being seen. Ten patients needed an operation for an acute attack and 10 for chronic symptoms. At

the end of the follow up 11 of the 14 patients treated surgically who were still alive had a permanent abdominal stoma. The cumulative probability of surgery was 35 (SD 7)% at five years and 39 (7)% at 10 years (figure).

Cumulative probability of surgery in 57 patients with colonic Crohn's disease with symptoms lasting less than six months.

During follow up 15 patients died; the expected mortality was 10. The cause of death was known in all patients: Crohn's disease was a contributory factor in four cases, and in 11 the cause was unrelated. During medical treatment 42 patients received sulphasalazine, 29 systemic corticosteroids, 20 azathioprine, and nine antibacterial drugs. At the end of follow up the 28 patients who had been treated conservatively were well. Seventeen were not taking any drugs, eight were taking sulphasalazine (plus steroids in one case), and three were taking systemic steroids (plus azathioprine in one case).

Comment

In a similar study of 269 patients with ulcerative colitis the probability of surgical treatment was only 8 (2)% at five years and 15 (4)% at 10 years,² whereas in this series it was four times as great at five years although less than three times as great at 10 years. Three deaths related to their disease occurred among the 269 patients with ulcerative colitis, compared with four among the 57 patients in this series with Crohn's disease. The present analysis shows that when surgery was required it was necessary in the early years of the disease, whereas after five years there was little likelihood of surgery. In both series about half the patients who needed surgery did so within the first year of being seen. In four cases severe anal lesions were the reason for the first operation involving a stoma.

In a previous study restricted to patients after their first admission to hospital for colonic Crohn's disease 72% required abdominal surgery within six years after admission.³ This proportion is similar to that in another published series.⁴ Our report may give a more representative picture of the prognosis because of the inclusion of 15 patients treated only as outpatients and the uniformly short history, and it is in keeping with another recent series.⁵ Our experience suggests that about half of all patients with colonic Crohn's disease can be treated successfully without abdominal surgery and that the need for treatment with drugs tends to decrease with time.

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(Accepted 22 April 1985)

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