publications: most proposals are based on the ideal district with a single district general hospital. Elsewhere it acknowledges that most people do not work in such a setting and that the biggest problems are in the conurbations, where all too often social disadvantage is associated with a confused health service for children. The report emphasises that it is time to recognise that in cities and large conurbations the district general hospital concept is often inappropriate or harmful to children's services. The only way to achieve a safe standard of care for children is by the aggregation of children and the concentration of skilled staff and expensive resources where they can be most economically used. This may mean one hospital having no child inpatients or all the child casualties going to one designated accident emergency unit rather than the two others in that city. It is in our cities that the greatest wisdom and skill will be needed in creating the sort of services our children and our future require.

[1] Committee on Child Health Services (chairman, Professor S D M Court), *Fit for the Future*. Volumes 1 and 2, price £10·50. London, HMSO, 1976.
[2] *British Medical Journal*, 1976, **2**, 1524.

Grief and stillbirth

Stillbirth is a tragedy for the mother and her immediate family, but it also affects the attendants deeply. When the death is diagnosed before birth the latter are anxious whether to tell the mother as well as the father. Brave attempts are made to bolster up her courage and fortitude during labour. More drugs may be offered in the hope that they will allay the distress, while forceps delivery and episiotomy seem empty, adding only to continuing distress and pain. A dull, sad quietness pervades the labour ward as the baby emerges, and its floppy body is hurriedly wrapped in a sheet and whisked away. There is no joy; only a sense of complete and utter failure. It is little different when the stillbirth is unexpected, except for the frantic efforts in resuscitation as the silence becomes increasingly oppressive, raising everyone's anxiety, especially the mother's. And again the baby is usually hurried away.

Telling the mother and the father is a horrid task, and however sympathetically done there is a feeling of incompetence in relieving the distress and helplessness in the face of heartbreak. The essential motivation of medicine is to relieve suffering, and here is a denial of that possibility. The response of all is usually to withdraw and not communicate, the well-known phenomenon of rejection. The various attendants may discuss the reasons for the stillbirth and rehearse what went wrong, partly as a means of reducing their own tensions. But often the persons most affected emotionally are unwittingly ignored and left to their own devices.

Recently, however, there has been growing recognition of the importance of acting out grief and the support of the survivors when there is a death in the family. Methods of helping have been identified and recommended,[1] but so far there has been relative neglect of the grief induced by stillbirth. Bourne[2] confirmed the tendency of general practitioners to forget the details of stillbirths as compared with their remembrance of live births. Moreover, there was some evidence of mothers being dissatisfied with the help they received, in that many of them transferred to other doctors. Another understandable finding was that more of the mothers who had had a stillbirth became pregnant again quite quickly, and they attended antenatal clinics earlier in the pregnancy than other multiparae.[3] Other papers dealing with emotional reactions to stillbirth have emphasised numerically what seems to be predictable to informed insight.[4–8] Of course, there is much variability in the responses of the bereaved. Not all of them start another baby; some return to former jobs, and others fling themselves into a wide variety of time-consuming tasks. The part played by the husband in shaping these decisions is not really known.

In general, for emotional reasons medical attendants have not faced this issue rationally and have not worked out a policy for helping those bereaved by stillbirth. Lewis[9] has recently pointed out that there is not a person to grieve over, only a potential person. In this there is analogy with the grief of some young widows who mourn the loss of the future with their husbands rather than the past. Lewis argues that the parents should be given something tangible to remember and so should touch and see the dead baby, and moreover that they should help with certification and arrange for a proper funeral or cremation, which they and the other children of the marriage might attend. There might well be a marked grave rather than the unfeeling oblivion of a common one. It is "necessary to help the parents to create memories, to bring the baby back to death in their mind." Kübler Ross[10] has delineated some of the common patterns of grief, and understanding of these helps with their alleviation. They are no less important in stillbirth than in deaths at a later age.

[1] DHSS, *Care of the Dying*. Reports on Health and Social Subjects no 5. London, HMSO, 1972.
[2] Bourne, S, *Journal of the Royal College of General Practitioners*, 1968, **16**, 103.
[3] Illsley, R, in *Childbearing—Its Social and Psychological Aspects*, eds S A Richardson and A F Guttmacher. Baltimore, Williams and Wilkins, 1967.
[4] Newton, N, and Newton, M, *Journal of the American Medical Association*, 1962, **181**, 206.
[5] Wolff, J R, Nielson, P E, and Schiller, P, *American Journal of Obstetrics and Gynecology*, 1970, **108**, 73.
[6] Giles, P F H, *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 1970, **10**, 207.
[7] Jensen, J S, and Zahourek, R, *Rocky Mountain Medical Journal*, 1972, **69**, (11), 61.
[8] Lewis, E, in *Psychosomatic Medicine in Obstetrics and Gynaecology, 3rd International Congress, London 1971*. Ed N Morris. Basel, Karger, 1972.
[9] Lewis, E, *Lancet*, 1976, **2**, 619.
[10] Kübler-Ross, E, *On Death and Dying*. London, Tavistock, 1970.

Beauty spot or blemish?

Such is the human condition that everyone has at least one distinguishing birthmark; so it is just as well there are few medical indications for treatment. Developmental anomalies arise from the limited number of elements in the skin, and the various lesions can usually be identified by the trained eye, making it possible to give the patient a fairly accurate diagnosis and prognosis. The cause of most birthmarks is conjectural. A few are genetically determined—Mongolian spots, ashleaf leukoderma in epiloia, lentigines in Peutz-Jeghers syndrome—but the great majority are presumed to be a result of simple mismanagement by the tissue organisers.

Clearly the genetic constitution of a population may determine the incidence of birthmarks. This is supported by the few clinical studies of birthmarks in neonates, which not surprisingly show a greater frequency of pigmented anomalies

(including melanocytic naevi, lentigo, and Mongolian spots) in the more pigmented races.[1 2] In a recent study[3] of 1058 neonates only 2% had proved pigmented naevi—0·4% lentigo and over 1% melanocytic naevi—and, since these "birthmarks" are universal, most naevi must in fact develop later in life. Indeed, pigmented naevi do grow and multiply during childhood, adolescence, pregnancy, and the climacteric. The risk of malignant change is negligible except in the rare giant pigmented naevus,[4] which is always present at birth, and which merits prophylactic surgery. Nature does sometimes destroy a naevus spontaneously in a remarkable immune phenomenon known as Sutton's naevus—leukoderma acquisitum centrifugum—when a white halo appears around a naevus and engulfs it. Otherwise treatment may be prompted by cosmetic considerations precipitated by an increase in size, or the patient may become anxious about her naevus, especially if it begins to grow hairs. Curettage, cautery, or shaving flush with the skin are reasonable alternatives, but the preferred treatment is by excision—though the insult of a surgical scar must always be weighed against the cosmetic offence of nature's blemish.

The common vascular naevi are of three types. Firstly, salmon patches may be found in over 40% of neonates.[1] Fortunately those on the face are evanescent, but those on the scalp may persist into adult life.[5] Secondly, strawberry marks —capillary vessel tumours—develop in over 1% of babies; few are detectable at birth, though some may be apparent as telangiectatic areas surrounded by a pale halo.[6] The typical tumour is obvious by six weeks, and it then takes up to a year to reach its maximum size. Involution is spontaneous, sometimes starting in the first year of life, but it is slow, and the mark may take several years to resolve completely. Nevertheless, nearly all have involuted fully by puberty. When marks are exposed to maceration by the napkin ulceration may be a problem; treatment may be needed with topical antibiotics and protective dressings. Injury may cause bleeding, but pressure will control it. In large or multiple lesions sequestration of platelets may result in haemorrhage (the Kasabach-Merritt syndrome), which is best treated by systemic steroids; a daily dose of 10 to 30 mg prednisone according to infant weight is needed for three weeks. This same treatment may be necessary should a strawberry mark interfere with feeding or the development of a vital organ such as the eye.[7]

Surgery has little to offer in treating strawberry marks, except that plastic revision may be required to deal with redundant skin from the involution of large lesions. Radiotherapy does hasten involution, but it is no longer considered good practice because the resultant scar is more unsightly than that arising from natural involution, and it may prejudice the natural growth of underlying and adjacent tissues. In general, a policy of firm reassurance and non-interference is to be preferred. Thirdly, the port-wine stain (found in less than 0·3% of the population[1]) is invariably present at birth. It follows a dermatome pattern and darkens slowly during life to assume its titular colour. Since no treatment is of any avail patients may need to use the excellent cosmetic cover preparations available. Sometimes stains may be surface markers of underlying vascular anomalies, as in the Sturge-Weber syndrome, where there is an associated intracranial lesion. When found on a limb a port-wine stain may be associated with haemangiectatic hypertrophy and arteriovenous communication.

Other naevi are uncommon. The naevus sebaceus of Jadassohn is present at birth as a fawn bald patch on the scalp; it becomes warty and darker with age, but in up to 30% of cases a neoplastic tumour develops in middle life,[8] so prophylactic surgery may be wise when the patient is old enough. Epidermal naevi start as yellow streaks; they also become warty and darker, but they are benign; they may be quite extensive, and, since they follow a dermatome distribution, surgery may be difficult.

[1] Jacobs, A H, and Walton, R G, *Pediatrics*, 1976, **58**, 218.
[2] Pratt, A G, *Archives of Dermatology and Syphilology*, 1953, **67**, 302.
[3] Walton, R G, Jacobs, A H, and Cox, A J, *British Journal of Dermatology*, 1976, **95**, 389.
[4] Reed, W B, *et al*, *Archives of Dermatology*, 1965, **91**, 100.
[5] Øster, J, and Nielsen, A, *Acta Paediatrica Scandinavica*, 1970, **59**, 416.
[6] Hidano, A, and Nakajima, S, *British Journal of Dermatology*, 1972, **87**, 138.
[7] Fost, N C, and Esterly, N B, *Journal of Pediatrics*, 1968, **72**, 351.
[8] Mehregan, A H, and Pinkus, H, *Archives of Dermatology*, 1965, **91**, 574.

Less usual forms of epilepsy

Kinnear Wilson[1] said that a faint, a cry, or a laugh could be a fit and that no rigid semilogical framework could embrace all epileptic phenomena. Yet 50 years later neurologists are still fascinated by a wish to classify and categorise the multifarious fragments of an epileptic attack, which may be facets of a complex seizure or provide a patient's only presenting symptom. Epilepsy may be triggered by external stimuli[2]; and, whereas there are accepted interpretations of the commoner components of temporal lobe abnormalities, the less usual manifestations of epilepsy continue to intrigue and baffle. Recently, Sethi and Surya Rao[3] have published a finely written account of a patient with epileptic laughing, crying, and running in whom they found a well-circumscribed tumour of the left temporal lobe. In a complementary report[4] Offen *et al* described a patient in whom temporal lobe atrophy was associated with paroxysmal attacks of weeping, facial contortion, head turning, and amnesia.

The location of laughing (gelastic), crying (quiritarian or dacrocystic), and running (cursive) epilepsy in the temporal lobe is supported by the common concurrence of other clinical phenomena. Amnesia for the event is usual. Head turning has been reported in four out of six cases of crying epilepsy,[4] and the presence of epigastric auras points to the temporal lobe juxtaposition of visceral, expressive, and affective functions.[5] Many studies have provided evidence of temporal and frontotemporal electroencephalographic foci, but the EEG patterns are not stereotyped: Gumpert *et al*,[6] for example, found reduced electrical activity during the periods of laughter.

The term gelastic epilepsy (gelos = mirth) includes both a subjective experience of merriment (Dostoievsky described seizures of pleasure and harmony[7]) and complex co-ordinate movements with grinning, giggling, or joyful weeping. Patients usually experience a change in mood in parallel with its involuntary external expression: so that the internal states of pleasure or happiness, fear or terror, may respectively be exteriorised as smiling or laughter, crying or sobbing, attempt at flight or fight.[8]

Although the temporal lobe is most frequently inculpated in emotional epilepsy, grey matter elsewhere may be affected,[9] and one cannot always analyse the nature of the episode. Roger *et al*,[10] reviewing accounts of epileptic attacks accompanied by laughter or smiling found that where these were accompanied by EEG foci, temporal or occasionally Sylvian, further analysis was usually possible; but in over half the cases the laughter or smiling had accompanied petit mal and it was impossible to gauge the affective content of the attack. Two