Trends in Causes of Infant Death

The infant mortality rate for NSW has more than halved over the 20-year period, from 19.6 deaths/1,000 live births in 1969, to 8.9/1,000 in 1987 (see Figure 2). There was a 42 per cent decline from 1970 to 1979, with a continuing, but smaller decline from 1980 to 1987 (13 per cent).

Deaths due to perinatal causes or conditions (ICD-8, ICD-9 760-779) fell by 68 per cent from 1969 to 1987. Most of this decrease occurred in the 1970s. Conditions originating in the perinatal period include those where the death may occur later. "Perinatal conditions" includes maternal causes and other conditions of the respiratory system. Over the period 1969-87, the reported infant mortality rate from respiratory causes (ICD-8 1-136, ICD-9 1-139) and does not include organ-specific infections such as pneumonia or meningitis. It is of interest to note the sudden reduction in the rate of deaths apparently due to infections in 1978, coinciding with the introduction of ICD-9. This probably is a result of the diagnostic grouping "infections specific to the perinatal period" having been transferred from the rubric "infections" to the rubric "perinatal conditions". There may also have been some diagnostic transfer from infections to SIDS.

Respiratory diseases (ICD-8, ICD-9 460-519) include acute respiratory infections, pneumonia, influenza, chronic disease and other conditions of the respiratory system. Over the period 1969-87, the reported infant mortality rate from respiratory diseases decreased to the same extent as that from SIDS increased. In summary, infant mortality is gradually declining in NSW. The major components of infant mortality — deaths due to perinatal causes and birth defects — are also decreasing. Deaths attributed to SIDS are increasing at a slow rate in NSW. This is of some concern when other countries have lower infant mortality rates than Australia, primarily because of lower SIDS rates.

Diagnostic transfer or real increase in SIDS? Unexpected infant deaths did occur before 1969, but (as suggested above) the lack of a formal SIDS rubric in the ICD before 1979 resulted in a number of alternative diagnoses being used. Mild or moderate respiratory tract infection is a frequent autopsy finding in cases of unexpected infant death and, although...
not of sufficient magnitude to cause death, may have been assigned as the cause of death when SIDS was not available. Accidental suffocation and, to a lesser extent, non-specific infections may have been used as diagnoses before the introduction of SIDS. The apparent increase in the occurrence of sudden deaths of infants in the 1970s reflects these changes in diagnostic practice.

The difficulty lies in determining if and when the process of diagnostic substitution ceased to occur, and whether there has been a true increase in the occurrence of SIDS. This is complicated by the nature of SIDS—a diagnosis of exclusion—that is dependent on the skill and experience of the examining pathologist. The latter would vary across NSW. These factors make any retrospective judgment on the true occurrence of SIDS susceptible to error.

In England there was a consistent rise in unexpected infant deaths from 1979 to 1987. At the 19th International Congress of Paediatrics in Paris in 1989 it was reported that the incidence of SIDS was rising in Sweden, Finland, New Zealand and parts of the United Kingdom. The increased occurrence of SIDS in Sweden and New Zealand is regarded as a real increase. If the true occurrence of SIDS is increasing in NSW, there will be considerable pressure for further research and development of programs to prevent it.

The first task in NSW is to ensure a consistent diagnosis of SIDS across the State, together with timely infant mortality data. This will provide reliable data on the incidence of SIDS to identify trends, and monitor any preventive programs.

Any attempt to prevent deaths due to SIDS requires some understanding of SIDS and how these deaths occur. Our present knowledge of the epidemiology of SIDS has identified several risk factors or associations for SIDS, but any causal factor or sequence of events remains elusive. Even without knowing the precise causes or mechanisms resulting in the sudden and unexpected death of an infant, it is possible to take action to reduce the frequency of the factors associated with SIDS.

Careful evaluation of prevention programs is necessary to identify any subsequent changes in SIDS mortality and determine which programs are effective.

EDITORIAL NOTE

A strong association has recently been demonstrated between the occurrence of SIDS and the prone sleeping position. Associations with smoking and non-breast-feeding have also been reported. In several parts of the world the SIDS incidence appears to have declined in parallel with promotional campaigns which focus on sleeping position, non-smoking and breast feeding. The NSW Health Department now recommends that infants be placed to sleep or on their sides or supine, unless medical advice is given to the contrary or the baby will only settle in a prone position. The SIDS incidence is being monitored.

Peter Lewis, Public Health Officer, Epidemiology and Health Services Evaluation Branch


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The staff of the Western Sector Public Health Unit and Michael Frommer, Deputy Director, Epidemiology and Health Services Evaluation Branch, for his comments and suggestions.

HYPERTENSION MANAGEMENT IN GENERAL PRACTICE

A comprehensive reference for diagnosing, assessing, investigating and managing hypertensive patients will be distributed to 4,000 GPs in NSW in March. This project is being supported by the Royal Australian College of General Practitioners and the NSW Health Program.

Hypertension is a detectable and treatable problem in Australia. As part of a strategy to address and control the problem a manual, called Hypertension — Diagnosis, Treatment and Management, has been produced for general practitioners.

The manual was produced after survey results from South Australia indicated the need for a comprehensive, integrated approach to the control of hypertension. An expert committee comprising general practitioners, specialists and behavioural scientists, was responsible for developing the manual. It was then produced by the Research Unit, South Australian Faculty, Royal Australian College of General Practitioners.

The manual has been endorsed by a number of recognised professional bodies and individuals in NSW, including the National Heart Foundation; the Australian Medical Association; Dr Sue Morey, Chief Health Officer, NSW Health Department; and the High Blood Pressure Research Council.

A directory of community resources useful for patients with hypertension is included in the package. There is also a list of agencies to which GPs can refer patients for advice and information on weight management, nutrition and smoking cessation. Charts for monitoring hypertensive patients, which can be incorporated into patients' records, are included. It is expected the manual will assist GPs to continue their important role in preventive care.

Copies of the manual have been printed by Sandor Australia. It will be distributed with the March issue of Patient Management. For information about further copies of the manual contact Kate Lamb, NSW Health Department, phone (02) 391 9585.

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The editor is Dr George Rubin, Director, Epidemiology & Health Services Evaluation Branch, NSW Health Department. Please send your articles, news, comments or letters to him at Locked Bag 961, North Sydney NSW 2059 or fax (02) 391 9232. Suggestions for improving the content of the Bulletin are welcome.

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