poor perfusion. His respiratory rate was 80–90/min with wheeze, inspiratory stridor, central cyanosis, and an oxygen saturation of 85% in air. His heart rate was 160/min and there were profuse oral and nasal secretions requiring repeated suction. The pupils were constricted but the child was too agitated for formal neurological assessment. The cyanosis responded readily to facemask oxygen. Over a period of 24 hours his respiratory rate settled and he remained well saturated in air. However, two hours after admission the boy's eyes became inflamed and an ophthalmological examination revealed bilateral superficial corneal scarring. There was also a chemical conjunctivitis making it impossible for the infant to open his eyes. The child was treated with regular saline (0.9%) irrigation and chloramphenicol prophylaxis, the inflammation settled over the next four days. Fortunately there was no residual scarring.

We have been unable to find any reports of nasal instillation of Olbas Oil in infants. Olbas Oil contains oils of peppermint, clove, eucalyptus, menthol, and cajuput but it is the latter three that cause the respiratory symptoms. Menthol and eucalyptus are terpenes that if ingested may cause epigastric burning, nausea, vomiting, dizziness, miosis, tachycardia, and a feeling of suffocation. In infants cyanosis, delirium, and convulsions may occur.¹ The respiratory symptoms associated with instillation, although dramatic, resolve eventually and treatment is supportive.

Oral poisoning with menthol and eucalyptus oils has occurred in the UK^{2,3} but nasal instillation is more common in Europe where bottles may be confused with normal saline.⁴ However, ocular involvement has been described only after direct application of camphor and eucalyptus.⁵

In young children nasal instillation causes immediate respiratory distress and agitation. This can lead, as in this case, to ocular administration. In patients with severe respiratory symptoms, needing oxygen or ventilation it is important to get an ophthalmic opinion. Untreated the oils can cause local burning and permanent corneal scarring.

JPW is supported by the Joseph Strong Frazer Trust.

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Pseudomonas cepacia

EDITOR.—The spread of *Pseudomonas cepacia* through previously stable populations of cystic fibrosis clinics is an increasing cause for concern. Anxiety has arisen after observations that some patients with previously mild

disease experience an accelerated and fatal deterioration in lung function after colonisation with the organism.¹ Early surveillance studies in the UK suggested a maximum prevalence of 7%,² however, this has risen in recent reports to approach the 40% described in contemporary studies from North America.³ The organism, which is an environmentally ubiquitous plant pathogen, is nevertheless surprisingly difficult to isolate from the environment; a recent American study only obtained 15 isolates from 900 cultures.

Mounting evidence of person to person transmission⁴ has led the Cystic Fibrosis Trust to issue guidelines for the management of colonised patients. This advocates segregation for both inpatients and outpatients, with restrictions on socialising and group activities. *P cepacia* positive patients, therefore, feel frightened and victimised. To address the concerns within our own clinic we have looked for evidence to support person-to-person transmission of the organism.

Sputum samples from all 118 patients attending both the adult and paediatric cystic fibrosis clinics in Sheffield were routinely cultured for the detection of *P cepacia* on Mast *P cepacia* selective agar (Mast Diagnostics Ltd, Bootle). Suspect colonies were further identified by the API 20NE system (BioMerieux, Basingstoke). However, as the API 20NE system cannot differentiate between isolates of *P cepacia*, ribotyping techniques were employed. Traditional ribotyping detects genomic restriction fragment length polymorphisms by probing the extracted chromosomal DNA with ribosomal RNA. The analysis of DNA rather than phenotypic characters provides a more stable determination of isolate identity.

Ribotyping using the restriction endonuclease enzyme ECO R1 (kindly performed by Dr Ty Pitt; Central PHLS, Colindale, London) was performed on all strains of *P cepacia* isolated in 1992/3. The five patients positive for *P cepacia* within this period (three of whom were previous positives) had strains with differing ribotype patterns. None of the patients exhibited the 'epidemic' S3/PO: ribotype A strain, nor was there evidence of a rapid deterioration in pulmonary function in this group of patients with forced expiratory volume in one second (FEV₁) essentially unchanged compared with values 12 months before and 12 months after isolation of the organism (table).

Although the modes of transmission of *P cepacia* remain unclear, epidemiological evidence from this study suggests person-to-person spread has not occurred in this cystic fibrosis population. In the absence of the epidemic type A strain, strict segregation may not be necessary.

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Change in FEV₁ after acquisition of *P cepacia*

Patient No	Age first positive (years)	Date	FEV ₁ (% predicted)			Genotype	<i>Pseudomonas aeruginosa</i>	<i>Aspergillus</i>
			Previous	At isolation	After 12 months			
1	14	14.7.87	41	29	36	508/508	+	+
2	4.1	25.8.91	N/A	N/A	N/A	508/N	+	
3	25	15.4.93	58	56	52*	508/508	+	
4	14	17.6.92	49	40	45	508/N	+	+
5	12	3.8.92	57	50	65	508/508	+/-	+

*FEV₁ seven months after isolation. N/A=not available.

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BOOK REVIEWS

Childhood Onset Anorexia Nervosa and Related Eating Disorders. Edited by Bryan Lask and Rachel Bryant-Waugh. (Pp 263; £19.95 hardback.) Lawrence Erlbaum Associated Ltd, 1993. ISBN 0-86377-294-3.

This book emanates from the professionals working in the children's inpatient unit in the Department of Psychological Medicine at the Hospital for Sick Children in Great Ormond Street. It draws on relevant literature and the professionals' own experience working with young people below the age of 15 who have anorexia nervosa or related eating disorders. The intention is to fill a gap. Although there are many books about anorexia nervosa, nothing focuses specifically on this age group. The intention appears to be very practical, namely to provide the appropriate background and guidance to those professionals concerned with the direct treatment of children with these disorders.

The book falls roughly into two halves apart from a challenging initial chapter from a parent. The next five chapters review relevant literature concerning the description and classification of these eating disorders, physical aspects, epidemiology, aetiology, and prognosis and outcome. A chapter on assessment is then followed by nine chapters about overall management and the various contributions to treatment including nursing, physical treatment, behavioural and cognitive approaches, individual psychodynamic psychotherapy, group therapy, and finally schooling.

This book is very practical in its orientation and easy to access. Chapters are very clearly structured with a liberal use of headings.

There is a critical approach to relevant literature, but research is not described or discussed in detail. The best chapters from a therapeutic point of view are excellent in giving specific and detailed examples of therapists' actions in particular contexts. Outstanding in this respect are the management overview and the chapter on family therapy and parental counselling by Lask and Magagna's account of individual psychodynamic psychotherapy. Some of the other chapters would have benefited from the use of such detailed examples.

The title of the book identifies its scope more clearly than does the prologue as it is definitely not a book about eating disorders in young children. Although the initial overview lists seven disorders considered relevant including food avoidance emotional disorder, pervasive refusal and bulimia, in practice this volume contains remarkably little about disorders other than anorexia nervosa. It would have been advantageous to show if similarities and distinctions between these different subgroups could have been considered in a systematic way throughout. There is an interesting contrasting of some of the disorders in the chapter on schooling. Bulimia in particular gets very little mentioned except under epidemiology. Overall this book is strongly recommended to practitioners working in this field.

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Neurological Problems in Childhood. By Neil Gordon. (Pp 339; £40 hardback.) Butterworth-Heinemann, 1993. ISBN 0-7506-0898-6.

With the publication of a number of new titles in recent years, there is now a good selection of medium sized and larger textbooks of paediatric neurology. The reader who seeks an introduction to the subject has hitherto not had such a good choice. Dr Neil Gordon's book, which is a completely updated version of *Paediatric Neurology for the Clinician* published in 1976, is particularly suited to doctors in training in hospital paediatrics and community paediatrics, as well as to those in allied professions.

This is a well written, very readable book. It manages to be quite comprehensive within its only 339 pages. There is a particularly good section on educational and developmental disorders. Epilepsy, muscle disorders, and cerebral palsy each has a succinct, well referenced chapter devoted to it. Despite the emphasis on common disorders, a large number of neurometabolic disorders are covered in the chapters on degenerative cerebral diseases and genetically determined conditions.

The omission of any review of neonatal neurology and the small space devoted to clinical genetics detract a little from the book's role as a short, comprehensive text. This apart, it is difficult to find important topics that have been overlooked. Fragile X syndrome is poorly covered, and there is no mention of HIV in an otherwise good section on central nervous system infection. The lack of magnetic resonance imaging is disappointing, but the book is otherwise well supplied

with many clear and appropriate black and white photographs.

I would have no hesitation in recommending this book to doctors training in paediatrics who need a good introduction to paediatric neurology. This book will be more than adequate to assist with preparation for the Paediatric MRCP Part 2. It will continue to serve the reader well, and there are sufficient up to date and key references in each section for it to be a starting point on the quest for more detailed knowledge about particular topics.

CARLOS DE SOUSA
Consultant paediatric neurologist

Children with Disabilities. A Medical Primer. 3rd Ed. By Mark Batshaw and Yvonne Perret. (Pp 664; price not stated, paperback.) Paul H Brookes, 1992. ISBN 1-55766-102-2.

If like me you were a trifle postictally confused after reading about and attempting to understand the different types of seizures, then I would recommend that you read the chapter on seizure disorders in *Children with Disabilities*.

Like all the various topics covered in this reader friendly book, which is intended for parents and educationalists as well as health care workers, the chapter begins with a set of objectives that the reader will achieve upon completion of the chapter, an introduction which puts the subject under discussion in perspective, followed by a clear description of the conditions (dotted with up-to-date references) the diagnostic procedures, treatment and multidisciplinary management, and ends with case histories ('based on actual and synthesized cases') and a summary. There are many very helpful illustrations, graphs, and charts (black and white) throughout the book.

Children with Disabilities begins at the beginning with 'the cell' and in a delightfully lucid way explains the basics of genetics, embryology, fetal development, etc, so as to give an understanding of where things can go wrong, and gives a comprehensive coverage of a wide range of disabilities in its 29 chapters. Appendix 'A' provides an extensive glossary, Appendix 'B' is on 'syndromes and inborn errors of metabolism'. Being an American book, Appendix 'C' 'resources for children with disabilities' has listed North American organisations only; if it were feasible to provide an addendum with a list of British organisations, it would be excellent. Of course, some areas such as hyperactivity would be dealt with differently in British practice.

For such a good sourcebook perhaps a touch of colour would provide an added incentive to lure the reader but I am mindful that this may be offset by a higher cost.

For junior doctors working with children, reading *Children with Disabilities* would provide an excellent and a relatively pain free priming dose before they venture onto more technical texts.

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Synopsis of Pediatric Emergency Care. Edited by Jagannath Surpure. (Pp 432; £32.95 hardback.) Butterworth Heinemann, 1993. ISBN 1-56372-011-6.

Not long ago it was difficult to find a textbook dealing only with paediatric emergency care. Interested readers had to ferret out material from larger paediatric textbooks or look for paediatric nuggets in adult books. Now, the field of paediatric emergency care is well established as an entity and consequently there is a growing body of paediatric emergency medical literature. Broadly speaking there are two types of books; one takes a practical 'how to do it' approach. These manuals tend to be precise, rather dogmatic, with the main emphasis on rapid initial diagnosis, management and treatment – algorithms abound. The other type of textbook is less action orientated and more comprehensive of single diagnoses. These aim I assume to be used more in study than as a practical guide on the 'shop floor'. Jagannath Surpure has edited a book that falls somewhere between the two. The book has 43 authors, mainly from Oklahoma, and is divided into 12 parts. The first five parts cover resuscitation, acute airway management, circulation, poisoning, and trauma/ortho-paedics. The next five parts deal with emergencies that occur in systems (for example central nervous system, gastrointestinal, etc). The last two parts cover miscellaneous (for example, febrile child, abuse) and environmental emergencies. The book is 432 pages in length. Inevitably there are transatlantic differences in drug names (adrenaline/epinephrine is the drug in resuscitation), spelling, and in some cases differential diagnosis.

Page 355 suggests children with fever and petechiae, where the differential diagnosis may be Rocky Mountain fever, but who have a normal lumbar puncture, white blood count and temperature less than 40°C, have a reduced risk of bacterial infection. We would not wait to find out, but would assume meningococcal septicaemia and treat until proved otherwise.

The chapter on sexual abuse has an emphasis towards forensic evidence and says little about who should examine, when and where. The multiagency approach encouraged in this country is missing. Some of the tables are small (page 289) and difficult to read, others are excellent. Chapters on airway emergency, respiratory disorders, and trauma are uncontroversial as they stick to widely used guidelines from the Advanced Pediatric and Advanced Trauma Life Support schemes. The resuscitation algorithms for ventricular fibrillation, electromechanical dissociation and asystole, differ only in minutiae from the European ones.

I was surprised that drowning did not get more than a couple of lines. Each chapter has a list of useful references.

Would I buy it? Well would I use it for practical management? I think not, as there are other clearer guides for that. Would I refer to it in study? Maybe, but then I am more likely to go to bigger texts or journals for in-depth up-to-the-minute knowledge. It is good value for money, a nice size of book to handle, but this time I would give it a miss.

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