Correspondence

the case of a bruise on the side of the forehead, cheeks, or chin, even in at-risk infants. It is not uncommon for the truth (that they are really finger bruises) to be admitted after a Care Order has been obtained after more severe injury.

In older children, by contrast, bruises, even those resembling finger tip bruises, are common and can be accepted as accidental, as shown by Keen1 in his careful study of 3- and 4-year-old children.

In view of our observations, it was decided to assess the incidence of facial and other bruises in a random sample of babies under age 1 year. Altogether 620 examinations of naked babies who were attending either a local authority health clinic, or a hospital follow-up clinic were made.

Bruises were seen on 6 babies only.

Case 1: Age 10 months. Already walking, showed 3 typical small (less than 15 mm) toddler shin bruises on each leg.

Case 2: Age 11½ months. Already walking, showed one typical small toddler shin bruise and a swollen 15 mm central forehead bruise.

Case 3: Age 10 months. Actively crawling, showed a 5 mm bruise on the outer aspect of the right arm and a small scratch on the outside of the right thigh.

Case 4: Age 10 months. A crawling baby who was able to climb upstairs, showed a 10 × 10 mm bruise on the point of the chin, caused by slipping against the coffee table.

Case 5: Age 9 months. An active, crawling, climbing baby showed a tiny central forehead bruise, caused by a fall from a toy tractor.

Case 6: Age 3 months. Had a 5 × 10 mm bruise under the right eye, due to falling on the telephone.

It is interesting that in our study the bruises, with one exception, were seen in babies of at least 9 months, who were already actively crawling or walking. The facial bruises in these children were on the central forehead, or point of the chin and showed, or had shown, swelling due to ‘hard, contact’ injury. They were quite dissimilar to the finger tip and thumb bruises seen in child abuse and so clearly described by Hall.2

The exception, Case 6, caused us anxiety, especially as an older sibling had also had worrying incidents. It was considered that the problem was due to an unacceptable level of carelessness and the situation was closely monitored by the health visitor. When the family moved away a few months later, the new health visitor was alerted.

Of the 5 other cases, 4 bruises were on shins and only 1 on an arm (Case 3) and this was accepted as accidental.

This study shows that facial bruising is rare in infancy. It also suggests that, if genuinely accidental bruises do occur in this age group, they are different from finger bruises. We submit that health workers and social workers should not accept an alternative explanation for bruises on the sides of the forehead, cheeks, and jaws that look like finger bruises. We consider it unlikely that a baby falling from sitting against the cot bars, or rolling over on to a toy will sustain such a bruise.

References


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Total colonoscopy in children

Sir,

We read the report of Williams et al., with interest and offer the following comments.

Cleansing enemas (phosphate, tap water, saline) were used in all patients as an adjunctive bowel preparation for colonoscopy. Enemas may cause mucosal hyperaemia, petechiae, mucosal mucus depletion, and inflammatory changes in rectal mucosa—that is, endoscopic and histological changes which could be confused with those of inflammatory bowel disease. Since many patients with inflammatory bowel disease will have normal rectal mucosa endoscopically but be diagnosed on rectal histology alone, avoidance of confusing artefact on histology is vital.

In addition, cold mannitol was used to prepare some patients. Since the report of a fatal colonic explosion during polypectomy attributed in part to mannitol degradation in the colon, the use of mannitol as a bowel preparation has been eschewed.

Regarding sedation, we have had to use larger doses than the 50 mg pethidine and 10 mg diazepam quoted in order to achieve good analgesia and amnesia in children over age 8 years. We individualise dosage and often use 3–4 mg/kg pethidine intravenously (in addition to intravenous diazepam) to ensure a non-traumatic procedure for the child. We find the use of these doses to be safe if given slowly while the patient is closely monitored, and paediatricians and nursing staff are present in an endoscopy room well equipped for potential resuscitation of children. Need for naloxone or oxygen is rare.

Finally, we disagree that colonoscopy or polypectomy needs referral to an adult gastroenterologist. With the growth of paediatric gastroenterology as a separate but allied discipline, there should be adequate paediatric expertise to perform these procedures completely. All of our approximately 130 colonoscopies and polypectomies during the last 10 years have been performed by our paediatric gastroenterology staff or fellows in training under supervision.

We feel that children should be seen, instrumented, and followed by paediatricians who are, after all, in the business of working with children and families.

References

Although snare polypectomy and the use of the electro surgical unit may present no problem to the paediatric surgeon it is doubtful if many paediatric gastroenterologists can become sufficiently practised with the apparatus and its use to be really safe. We agree fully with the need to stimulate the growth of paediatric fibre-endoscopy in general and colonoscopy in particular, but it would be a pity if a spirit of chauvinism meant that paediatric gastroenterologists should wish to develop their endoscopic skills in isolation without the benefit of all the many lessons that their adult colleagues have learnt and would willingly pass on.

We take it that the comment that the UCLA colonoscopies and polypectomies 'have been performed by our paediatric gastroenterology nursing staff' is a misprint.

Which infants should not receive intensive care?

Sir,

I wish to point out a grave anomaly in an otherwise admirable article. Campbell is right in saying that decisions to withhold or withdraw intensive care are complex because they concern judgments that not only are medical but are moral, ethical, and legal and for which doctors have little or no formal training (page 569). The article itself undeniably shows that doctors, even senior medical practitioners (all of whom I presume have little or no formal training) have, nevertheless, learned from experience most moral wisdom there is to be gained. Most of it or all of it? Campbell seems to claim the latter. He finds it 'difficult to see how a “child advocate”, an ethics committee, or the Courts could do any better' (page 571). I wish to take exception to this statement as regards the ethics committees. Here, as elsewhere, the proof will be in the eating of the pudding.

Current ethics committees often have an audit function only, that is they review problems of the past. Why would not they be 'on call' to play an active role in treatment decisions? Thus they would meet a need so well described by some Canadian paediatricians who feel that regional, national, or local groups could advise concerning ethical decisions, in particular clinical situations. What would be the contribution of such groups to the decision and its implementation?

Firstly, an ethics committee would function at some distance from the immediate crisis centre. Being less directly involved will raise the committee's chances for objective and independent evaluation.

Secondly, over and above the consistency with the patient's or the team's conviction—which seems to be the main moral concern of decision making according to Campbell—the committee should be able to survey the total picture. Thus, the ethics committee, besides confirming the medical team's approach to individual and micro-ethical questions, would give due consideration to the macro-ethical aspects of immediate, short- or long-term range. It is doubtful that the average neonatology team has the expertise for such exploration.

Thirdly, it is likely that a decision to which an ethics committee made its contribution, would be more readily accepted because of its moral competency and authority.

Dr Williams and Dr Walker-Smith comment:

The practical comments offered by Hassall and Ament relating to paediatric colonoscopy are well taken. Any pathologist reviewing biopsies taken after bowel preparation should certainly expect to make allowance for a small increase in cellular infiltrate and significant mucus depletion. It is not our experience that either petechiae or significant erythema result from purgation or enemas, except for local trauma in the ano-rectal area.

The sweetness of mannitol makes it acceptable to children and there is no hazard if no electro surgery is contemplated; some of the alternative saline/saline plus PEG solutions are unpalatable but other proprietary mixtures—such as Picolax—might be a satisfactory alternative. We too individualise the dose of pethidine and diazepam (Diazemuls is now preferable as it is painless and non-toxic) using the least dose of diazepam to obtain amnesia but a generous dose of pethidine titrated to the particular child's requirement (which is often impossible on a mg/kg basis). We use nalorex for reasons of social convenience to the child and nursing staff for whom the very rapid reversal of sedation means that normal activities can be resumed within a few minutes of the end of the procedure.

The question as to who should perform colonoscopy in children is a more debatable one. There is no need for paranoia on this subject and doubtless the solution will be different in different centres according to the resources and staff available. It is our policy that paediatric gastroenterologists should be trained to do as much as possible and that most endoscopic procedures should certainly be done in the surroundings of the paediatric unit with which the child is already familiar. In many of our cases however, there is a positive indication for total colonoscopy including taking of biopsies in the terminal ileum. Limited examination is sometimes clinically sufficient and can easily be performed by the paediatrician, often without any sedation. Some total colonoscopies are surprisingly difficult and when a major centre such as UCLA Division of Paediatric Gastroenterology performs only an average of 13 colonoscopies a year it is difficult to imagine that many other paediatricians will acquire the dexterity or 'tricks of the trade' acquired by a specialised adult gastroenterologist performing at least a thousand procedures a year. It may be as a result of this facility that we perform about a hundred paediatric total colonoscopies a year as well as numerous limited examinations performed in the ward or outpatient clinic by paediatricians alone.
Total colonoscopy in children.

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Updated information and services can be found at:
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