falls from baseline in PEFR and FEV₁₋₇₅ of 31% and 36%, respectively, compared with falls after placebo of 33% both for PEFR and FEV₁₋₇₅.

We could not find any significant clinical benefit from clemastine as judged by symptom scores, asthma-free days, total bronchodilator usage, or twice-daily PEFR measurements at home (Table 2). The strongest trend noted was that 9 of the 15 children used fewer doses of salbutamol and other bronchodilators during the active period.

Discussion

Clemastine in a dose of 200 μg delivered by metered aerosol was a bronchodilator in these children. Our findings are similar to those reported by Norgrady et al.1 in adult asthmatics in whom the maximum effect was reached slowly. In this study we did not find any significant improvement from baseline in FEV₁₋₇₅ until one hour after inhalation of clemastine (Table 1). This makes it unlikely that clemastine would ever find a role in the management of acute asthma in childhood.

We observed no significant trends for the active drug period to be associated with less use of the bronchodilators, higher average morning PEFR at home, and higher baseline values for PEFR and FEV₁₋₇₅ in the respiratory laboratory. However, the overall results of the clinical trial (Table 2) are discouraging with regard to the efficacy of the specific H₁ receptor antagonist as treatment for chronic asthma. Only one child was strikingly better on clemastine than placebo. He was matched by 2 others who showed the reverse trend. Furthermore, the poor clinical response at home was probably not due to inadequate dosage and poor inhalation technique because we were able to measure significant bronchodilatation when the children used the metered aerosol in the respiratory laboratory.

Although we have shown that clemastine is a bronchodilator in a group of children with residual symptoms despite conventional treatment for asthma, this study does not suggest that clemastine will be a useful addition to the management of their asthma.

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References


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Relation between faecal fat and energy in preterm infants

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SUMMARY The energy measured in the faeces correlated highly (r = 0.93) with faecal fat in 111 24-hour stool collections from 37 preterm infants. It is easier to measure faecal energy than faecal fat, and energy measurements provide a better indication of nutrient malabsorption than faecal fat alone. Impaired energy balance and low energy digestibility are common in preterm infants.1 2 This is likely to be due mainly to fat malabsorption, but faecal energy is also derived from unabsorbed or endogenous protein and carbohydrate. The energy content of the faeces is fairly easy to measure by ballistic bomb calorimetry,3 whereas faecal fat
Cryptic mediastinal masses causing airways obstruction

D K C Cooper, A R Chrispin, M De Leval, and J Stark

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SUMMARY In 3 infants, severe airways obstruction was caused by mediastinal lesions which were not evident on the antero-posterior chest radiograph. Their presence was demonstrated by barium swallow examination. Each infant had thoracotomy carried out urgently. Duplication cysts (without associated cervicodorsal vertebral anomalies) were present in 2 patients and neuroblastoma in the third.

A congenital anomaly compressing the trachea or main bronchus may not be detected at an early stage, despite symptoms. There are two main reasons: (1) the history may be misleading, and (2) there may be nothing on the antero-posterior chest radiograph to suggest that the clinical and radiological features are secondary phenomena.

In cases of stridor, wheezing, or air trapping in the lung, careful scrutiny of the mediastinum for mass...
Relation between faecal fat and energy in preterm infants.

O G Brooke and C Wood

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