officer with day to day responsibility for the service to have complete autonomy and consequent power to protect/develop the service, working from the present health authority base. A senior clinical medical officer in child health feels a more natural affinity for the paediatrician with whom he works as a clinical colleague. The BPA must really take the initiative and act swiftly to promote an integrated child health service. Community medicine should be a planning resource only and the faculty bid to stay in control must be firmly resisted.

A SENIOR CLINICAL MEDICAL OFFICER

Juvenile discitis

Sir,

Hensey et al \(^1\) seemed unconvinced of the value of antibiotic treatment in their six cases of juvenile discitis. We have seen and treated four children (three under the age of 5 years) in the past four years with clinical, radiological, and laboratory features consistent with the condition as described by the authors (Table). None of our patients were systemically ill, although one, our first, did present with mild glomerulonephritis and in his case a throat swab yielded beta haemolytic streptococci Lancefield group A. All four patients responded to antibiotic treatment. Penicillin was stopped after 10 days in case 1 with recurrence of backache and inability to walk within a week. His symptoms resolved again within a few days of restarting penicillin and flucloxacillin and he remained well after being given treatment for a further 6 weeks. The other three children received antibiotic treatment for 6 weeks by which time the erythrocyte sedimentation rate had returned to normal in each case.

After two years follow up one of our patients had a recurrence of symptoms, but she again responded to antibiotic treatment with ampicillin and flucloxacillin and has since remained well after being given treatment for a further 6 weeks. The other three children received antibiotic treatment for 6 weeks by which time systemically ill, although one, our first, did present with mild glomerulonephritis and in his case a throat swab yielded beta haemolytic streptococci Lancefield group A. All four patients responded to antibiotic treatment. Penicillin was stopped after 10 days in case 1 with recurrence of backache and inability to walk within a week. His symptoms resolved again within a few days of restarting penicillin and flucloxacillin and he remained well after being given treatment for a further 6 weeks. The other three children received antibiotic treatment for 6 weeks by which time the erythrocyte sedimentation rate had returned to normal in each case.

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Correspondence

aetiology. Our experience is similar to that reported by others.1 2 If the condition is infective in origin one might expect, as in acute vertebral osteomyelitis, to find extensive local bony destruction, a more chronic course, and positive blood, biopsy or aspiration cultures.

In the two patients reported by Shah and Miller where an organism was isolated from blood cultures, we agree that antibiotic treatment was indicated. We would not agree that broad spectrum antibiotics should be offered to all cases. In the absence of proved bacteriological infection bed rest alone has been shown to be adequate treatment.1 3

Controversy will continue until a control study of antibiotic treatment is performed.

References


Pancuronium bromide induced joint contractures in the newborn

Sir,

I was interested to read that Drs Sinha and Levene have recently described four cases of joint contractures in the newborn which they associate with the use of pancuronium bromide.1 I note, however, that in the three cases they describe, these babies also received other drugs. They do not mention the route by which they received these drugs. If the route of administration was intramuscularly, I would postulate that this may be a factor that they fail to mention at all in their discussion. I recognise the development of muscle fibrosis as a result of repeated intramuscular injections in neonates. Presumably this could be severe enough to cause a joint contracture.

Reference


Dr Silverman comments:

My remit was to write about bronchodilators for wheezy infants. The topics mentioned by Drs Sills and Ory, the dietary management of wheezy infants and the use of nebulised steroid treatment, are both interesting and controversial. A recent review dealt with the thorny topic of cows’ milk free diets in allergic children.2 The place of inhaled steroids in the management of wheezy infants would merit a separate detailed review.

References


Minimum standards of neonatal care

Sir,

Working as a senior house officer in three different neonatal units recently and comparing notes with friends in other units has made me realise what a variety of protocols are followed in dealing with babies with meconium liquor and good Apgar scores. The most aggressive comprise routine endotracheal suction preceded by chest compression and followed by bronchial lavage, while the least go no further than oropharyngeal suction. In the last 10 years three published studies1-3 have tried to find out what protocol is best and produced two different answers. A review on the subject4 says that an aggressive protocol is current policy. The standards of neonatal care currently

Bronchodilators for wheezy infants

Sir,

We were interested in Dr Silverman’s detailed review of the problems of wheezing in small children.1 We were disappointed that no specific mention was made of the possible beneficial effects of a cows’ milk free diet in the management of chronic wheezers in the very young age group. We have found this anecdotally to be a useful measure which is often more acceptable and more effective than drug treatment.

In the discussion of bronchodilator treatment Dr Silverman makes no mention of beclomethasone dipropionate (Becotide) which we have used in a nebulised form in a dosage of 50 to 100 μg 4 hourly for wheezy children in this very young age group. We have had some success using this drug in this form and would be interested in Dr Silverman’s views.

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Drs Sinha and Levene comment:

We apologise for not having made it clear that all injections given to the three infants described were given by the intravenous route.