advancing the onset of the pubertal growth spurt and had no adverse effect on adult height prediction.

References

Ceftazidime in neonatal infections

Sir,

Ceftazidime has been shown to be effective against both Gram negative and Gram positive organisms commonly causing neonatal infections.1 It is now being used as a first line antibiotic for the treatment of neonatal infections for the reasons given by Low et al.2

Their analysis suggested that ceftazidime may not be effective against Gram positive organisms. I was surprised that case 12 was included. Would it not be too optimistic to expect sterilisation of the cerebrospinal fluid 6-75 hours after a single dose when using any antibiotic? Why (case 11) was penicillin only given 15 hours before death (day 11) when ceftazidime had been begun at 16 hours, the infant’s condition was deteriorating, and the organism was not sensitive? The persistence of Staphylococcus aureus (case 9), despite an adequate serum concentration, suggests that the child may have had an infected venous catheter or a collection of pus.

On the basis of this report I feel it is premature to abandon the use of ceftazidime as a first line drug for the treatment of neonatal infections.

I Blumenthal
Oldham and District General Hospital,
Oldham OL1 2JH

Drs Low and Bissenden comment:
Dr Blumenthal’s comments arise partly because our study was based on 14 cases of proved sepsis, each of which would have merited further discussion, and the need to restrict clinical data to the absolute minimum within the constraints of the Table. Nevertheless, there is obvious confusion over case 12. This was group B streptococcal meningitis, diagnosed early, treated promptly, and where sterilisation of the cerebrospinal fluid was achieved after 54 hours of treatment (not 6-75 hours—that was when the cerebrospinal fluid ceftazidime concentration was measured). It seemed a reasonable case to report, and we see no reason to exclude it. What is difficult to explain in that particular case, and in the case of staphylococcal septicaemia (case 9), is that despite these organisms, on the basis of their minimum inhibitory concentrations being sensitive to ceftazidime, and bacteriocidal concentrations of ceftazidime achieved in cerebrospinal fluid and blood, organisms could still be cultured after 54 and 36 hours respectively. Maybe there was a focus of infection seeding the blood in case 9, but flucloxacillin addition coincided with bacteriological eradication and clinical improvement. Finally, case 11 (also group B streptococcal septicaemia) was diagnosed late on the second day of life, as her symptoms had been ascribed to hyaline membrane disease. She continued to deteriorate throughout the next 15 hours of ceftazidime treatment (two doses), and penicillin was then added, which resulted/coincided in eventual bacterial eradication. Bilateral intraventricular haemorrhages had already occurred, however, and intensive care was stopped on day 11.

de Louvois’s article,1 quoted by Dr Blumenthal, no more shows ceftazidime to be effective against Gram positive organisms than our paper shows it to be ineffective; it merely reviewed theoretical advantages of ceftazidime, with which we would not argue. By no means should ceftazidime be abandoned for use in neonates on the basis of three cases of Gram positive sepsis which fared badly. Much more experience is necessary, but we can only say from our data that it was inappropriate as a single first line antibiotic.

References

Campylobacter enteritis and bloody stools in the neonate

Sir,

Surely a throw away remark as in the Discussion of the paper by Youngs et al1 should be either referred or edited out. I refer to ‘in our experience anal fissures are not infrequently associated with necrotising enterocolitis and other forms of colitis in the newborn’: this in a paper on campylobacter not necrotising enterocolitis or anal fissures. If mentioned it must surely be substantiated—what is their evidence?

Neil McIntosh
St George’s Hospital Medical School,
London SW17 0RE

Dr Youngs and co-workers comment:
The statement quoted by Dr McIntosh is based upon observations during an epidemic of necrotising enterocolitis in 1981 and 1982. The presence of inflammation of the distal large bowel in necrotising enterocolitis was shown by
Correspondence

Fenton et al in 1981. In three of our series of ten neonates diagnosed thereafter, fissures were present at the anal margin prior to endoscopy, and in a further infant diagnosed as non-specific colitis at laparotomy, multiple anal fissures were present. Details of the bacteriological and clinical features in these babies are in preparation for publication.

With reference to whether the offending statement should have been edited or refereed out, we would merely comment that this responsibility does not lie with the authors. Perhaps Dr McIntosh would have been happier if we had referenced the statement to the paper in preparation, rather than quoting from our experience.

References


Inaccurate coding corrupts medical information

Sir,

Data from the hospital activity analysis is unreliable for reasons including medical neglect and coding errors. Two other points are increasingly likely to become important.

Firstly, only the first diagnosis is recalled by the regional health authority computers. If a child who is microcephalic, mentally handicapped and affected by cerebral palsy, scoliosis, and epilepsy is admitted with feeding difficulties and weight loss which reflect a chest infection and benzodiazepine side effects, he could be coded by a doctor in one of at least 10 ways, including the underlying diagnosis or the social factor that precipitated hospital admission as opposed to outpatient treatment.

Secondly, the health authorities, in a search for efficiency savings, are likely to make increasing use of hospital activity analysis data in comparing treatment for people with specific conditions between authorities and departments. Unless the data collection is sensitive enough to distinguish between simple and complex cases, major errors could be made. In the North West Health Region the mean length of stay in hospital for a child coded as having epilepsy is 4.5 days. The regional child neurology service's mean length of stay is 3.5 days, however, if infants with refractory seizures are considered (far more likely in a regional centre) the figures will be greatly skewed. Their mean length of stay is 35 days.

Doctors may not have been concerned about data collection hitherto for two reasons. Most do not do research and they realise that the more fuss they make the more likely they are to be induced to do it themselves.

If the needs of the scientific frontiers have not moved us in the past, the laws of the financial jungle may do so in the future.

IAN MCKINLAY
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Reference


Changes in understanding of illness as the child grows

Sir,

Dr Eiser1 rightly draws attention to the need to understand the state of a child's cognitive maturity when giving information about any medical condition. A child's apparent inability to understand such information is not, however, necessarily determined solely by his intellectual development. There are many children whose failure to understand is a defensive manoeuvre by which they try to deny the existence of the disease. This is often true of some diabetic children where the implications of a serious condition requiring life long management is a daunting one. It should not be forgotten that childhood illness, particularly of a serious chronic type, has repercussions for the child and his family and 'not knowing' can represent the child's attempt to deal both with his own poorly functioning body and his parents' reaction to it.

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Reference

Dr Youngs and co-workers comment

*Arch Dis Child* 1985 60: 785-786
doi: 10.1136/adc.60.8.785-c

Updated information and services can be found at:
http://adc.bmj.com/content/60/8/785.4.citation

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