dent on achieving a good antipneumococcal antibody response and a serum antibody nitrogen concentration greater than 300 ng/ml is believed to offer protection for two to five years. If possible vaccination should occur two weeks before splenectomy as higher antibody titres are produced. When a splenectomy is performed as an emergency such as after abdominal trauma, however, vaccination should still be performed because the antibody titres achieved are considered to be protective in most cases.

Although vaccination is generally thought to be effective, overwhelming pneumococcal sepsis in previously vaccinated patients does occur. This may be due to several factors: (a) not all pneumococcal subtypes are covered in the vaccine; (b) the subtypes do not produce equal titres of antipneumococcal antibodies; and (c) the antibody titres, which may originally have been adequate, may decrease with time exposing the patient to pneumococcal infection.

Because of the latter reason revaccination of high risk adult patients has been performed with few side effects. In children, however, revaccination is not currently recommended within six years of the primary vaccination.

Primary vaccination in children under 2 years of age is currently not recommended because of poor antibody production.

The Pneumovax II vaccine fails to cover all the pneumococcal subtypes. The loss of protection with time after vaccination because of the falling antipneumococcal antibody titres, repeated measurements of which in high risk patients would be logistically difficult to organise, means there is a need for a second concurrent prophylactic measure.

Prophylactic daily penicillin, which would theoretically cover all the pneumococcal subtypes, has been shown to be effective in reducing the incidence of pneumococcal sepsis in postsplenectomy patients. Its indefinite prophylactic use has been recommended in one study. Poor compliance, allergic reactions, and the risk of producing penicillin resistant pneumococcal strains are the main problems cited with this approach.

Because of the previous reports on overwhelming postsplenectomy infection, together with our own experience, we strongly recommend for all children who undergo splenectomy:

1. Vaccination with Pneumovax II and revaccination at intervals of six years.
2. Continuation of penicillin indefinitely or at least until the child has left an environment where there is an increased epidemiological risk of pneumococcal infection, such as school, university, or the armed forces.
3. Continual parental awareness and vigilance.

6 Evans DIK. Fatal postsplenectomy sepsis despite prophylaxis with penicillin and pneumococcal vaccine. Lancet 1984;i:1124.

Visceral leishmaniasis in a Scottish child

P Galea, K M Goel

Abstract

A Scottish girl acquired visceral leishmaniasis (kala-azar) while on holiday in Majorca. She presented with the infection, six months later, in Scotland. Because of inexperience with the disease and a degree of scepticism unnecessary investigations were carried out resulting in a delay in treatment.

Visceral leishmaniasis (kala-azar) is found in an area extending from the Straits of Gibraltar, across the Mediterranean through Asia to China. The vector is a sandfly, which transmits the infection from the natural reservoir usually an infected dog, to human beings during feeding. The sandfly does not survive in the colder climates north of the Mediterranean and leishmaniasis is virtually unknown in these countries. Because of its long incubation period (six weeks to three years), however, it is possible for kala-azar acquired in an endemic area to present in a country where the disease is not endemic.

We describe the case of a Scottish girl who acquired kala-azar while on holiday in a Mediterranean country and presented with the infection in Scotland.

Case report

A 9 month old girl was admitted to the Royal Hospital for Sick Children, Glasgow, with a 10 day history of lethargy, pallor, fever, and poor feeding. On examination she was found to have a mass in the left hypochondrium. She was febrile and miserable. Her haemoglobin concentration was 65 g/l, white cell count 6·3×10^9/l, and platelets 41×10^9/l. Initially she was thought to be suffering from a malignant condition and was investigated accordingly. Bone marrow examination, blood culture, chest radiography, skeletal survey, and urine catecholamines were all normal. Abdominal ultrasound examination showed the mass to be a massively enlarged spleen.

She was given a blood transfusion and antibio-
Crohn's disease of the lung

J W L Puntis, M J Tarlow, F Raafat, I W Booth

Abstract

Two years after developing colonic Crohn's disease, a 17 year old boy presented with focal pulmonary consolidation. A lung biopsy specimen showed areas of non-caseating epithelioid granuloma. Although some respiratory abnormalities appear to be associated with inflammatory bowel disease, granulomatous disease affecting the lung has not previously been reported in a child.

Case report

A 15 year old boy was referred to hospital with a short history of diarrhoea, weight loss, and abdominal pain. Other features suggestive of inflammatory bowel disease included arthralgia, perianal inflammation, and erythema multiforme. At colonoscopy, a moderately severe pancolitis was found. Mucosal biopsy specimens were typical of Crohn's disease, showing non-caseating granuloma with epithelioid and histiocytic cells admixed with multinucleated giant cells (fig 1).

The patient remained symptom free on maintenance treatment with mesalazine 400 mg three times a day, but two years later, developed left sided pleuritic chest pain, intermittent fever, and lassitude. A chest radiograph showed...
Visceral leishmaniasis in a Scottish child.

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