under normal circumstances be recorded by our local coroner’s office. In our efforts to resolve the difficulty, we encountered a more complete but less detailed source of data. In those districts where child health surveillance and school health records are computerised, a comprehensive list is kept of children who have died in order that grieving parents are not inadvertently sent invitations to attend child health surveillance appointments. The list is usually complete and includes local residents who have died outside of the district boundaries. The information contained in these lists usually just extends to the child’s name, address, and cause of death with no further details. However, we found these records of use in supplementing data supplied by the coroner’s records.

We would concur with Dr Levene in her plea for a comprehensive prospectively compiled childhood accident mortality database. Coroner’s inquests and childhood health records will yield basic data which might, perhaps, be usefully supplemented by confidential inquiries into the circumstances of individual accidents. Collation of locally relevant data is a key element in child accident prevention which should be a priority for every health authority.

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Dr Rushforth and colleagues comment:
We note Dr Jones’ suggestion of a possible route of a percutaneous central venous catheter, via diploic veins, to lie in the middle meningeal vein to explain a subdural collection. However, the diploic veins are absent at birth and do not develop until around 2 years of age.\(^1\) The infant in the case report was still less than 37 weeks’ corrected gestational age at the time of the incident.\(^2\)

It may be possible to suppose passage of a catheter via an emissary vein to lie in the sigmoid sinus. However, this route is tortuous and would not be supported by the appearance on the original radiograph.

We agree that if a catheter will not advance, it is probably lodged in a small vein and should be withdrawn. End flow of blood back through the catheter would support its tip being in a large vein, as we in our case report.\(^2\) However, the ideal position for central venous catheters should be the right atrium where risk of retrograde flow is less.


Intraosseus infusion
SIR.—The intraosseous route for emergency infusions of fluids and drugs is used in this country and Drs Ryder, Munro, and Dowell do well to remind us of its simplicity and efficacy when vascular access is difficult and speed essential.\(^1\) However, when discussing the various sites for intraosseous infusion they include the sternum. This site is too hazardous to recommend in my opinion. The upper tibial shaft is safe and favoured as the intraosseous infusion site of first choice by most emergency physicians. The lower end of the femur or humerus are other useful alternatives.

Specially designed intraosseous needles are available and have a shelf life of approximately five years. Their advantage over using hollow shafted needles (for example a large butterfly or needle of large bore intravenous cannula) is that they are less likely to become blocked by debris or blood clots and can more easily be anchored in situ. Their cost is not prohibitive (about £10–£15 each) and it would seem appropriate for all emergency trolleys or boxes to include such needles. One size, such as 16 or 18, is usable in most situations for all ages of children.

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Familial asplenia
SIR.—We read the article on haemophilus septicaemia in congenital asplenia\(^1\) and the subsequent correspondence\(^2\) with great interest. We would like to describe our experience, which illustrates the importance of familial asplenia and also a potential disadvantage of not performing a necropsy.

A 21 month old girl, the second child of non-consanguineous white Australian parents, presented to a peripheral hospital with a short history of fever and delirium. She was profoundly shocked with widespread purpura and ecchymoses. A presumptive diagnosis of meningococcaemia was made, resuscitation with artificial ventilation, antibiotics and plasma was commenced, and transfer to this hospital was requested. On arrival here she was moribund and died within minutes. Blood cultures were sterile. Necropsy was requested but declined by the distraught parents.

The parents subsequently had a third child, a boy, who presented at the age of 4 months with fever and rapid onset of shock and purpura. He was found to have purpura fulminans, with confluent ecchymoses of his distal limbs, ears and nose, and with purpura on his lips. Cultures of blood and cerebrospinal fluid grew Streptococcus pneumoniae. Blood films showed numerous erythrocytes containing Howell-Jolly bodies. An ultrasound scan revealed no spleen and asplenia was confirmed by tomographic scan. The child’s spleen was normal. His sister’s original blood film was retrieved from the peripheral hospital and the red cells were also found to contain many Howell-Jolly bodies. The oldest child is well, has a normal peripheral blood film, and has a spleen on ultrasound.

The patient required intensive resuscitation with artificial ventilation, colloid, blood, and...
Health for all children.

D M Hall

Arch Dis Child 1992 67: 665
doi: 10.1136/adc.67.5.665-b

Updated information and services can be found at:
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