The preparation used by Shield et al had the same concentration of anticryptosporidial titres as preparations used and reported by other authors.1,2 As the patient died six months following the treatment, we believe it would be speculative to state that permanent clearance of cryptosporidia had occurred; significant reinfection may have been detected at some point in the future had the patient survived. It was not clear whether serum immunoglobulins had been abnormal during the course of the study and neither whether human serum immunoglobulin had been administered at any point; these are factors which may have had bearing on the clinical course.

It has been observed that colostrum contains significant concentrations of non-antibody immunologically active compounds including glycoconjugates that may have activity against cryptosporidia.8 The pathophysiology of cryptosporidiosis is unclear and lack of effective mucosal antibody may be only one part of a complex disease process. Thus may be why diverse approaches to enteral immunotherapy have all shown promise. There are no data available so far to confirm that one preparation is superior to another in the management of crypto-
sporidiosis affecting immunedeficient patients and I believe that continued single case reports will not clarify the situation. Controlled trials may enable comparisons to be made between different enteral prepara-
tions only in terms of effectiveness but also cost, palatability, dosage, and duration of treatment.

Inappropiate prescribing of promethazine in infants

EDITOR,—Several publications have indicated a possible link between phenothiazine administration and some cases of sudden infant death syndrome (SIDS).1,3 Prompted by the observation that four of seven infants presenting to one Belgian hospital with SIDS had received trimazepine in the days before death, a Danish and Blum prospectively studied 52 SIDS infants with information on nasal paracetamol infusion.21,25 They found 23% of SIDS victims, 22% of near miss infants, and 2% of controls were taking a phenothiazine preparation (with the exception of infants in each group who were suffering from nasopharyngitis).2,2 Furthermore, the same group investigated the influence of phenothiazines on cardiorespiratory and sleep characteristics in four normal infants.3 In these infants recordings showed an increase of 39% in the number of central apnoeas and short lived obstructive apnoeas on the treatment nights relative to the baseline administrations. These authors suggest that pheno-thiazines may cause central and obstructive apnoea in infants and reduced arousal and recommend that all central nervous system depressants avoided in children under 1 year. Alternative mechanisms for pheno-
thiazine induced apnoea have been suggested including an increase in endogenous opioid activity and an alteration in temperature regulation.4,5 Reviewing these studies Cantu et al felt that the data linking phenothiazines and SIDS was inconclusive but advised caution in the use of this class of drugs in infants less than 1 year in view of the risk of central nervous system depression and apnoea.6

We are concerned that promethazine is fre-
quently prescribed for children under 2 years despite recommendations to the contrary. On reviewing the notes of the 93 consecutive children under 2 years of age admitted to Birmingham Children’s Hospital with respira-
tory symptoms during the week before Christmas 1992, we found that 10% (six of 59 infants) of those under 1 year and 3% (one of 34 children) of those between 1 and 2 years were taking promethazine.

The manufacturers data sheet for pro-
methazine hydrochloride (Phenergan, Rhône-
Poulenc Rorer) states ‘not recommended’ in children less than 1 year and ‘use as recommended by a doctor’ in children from 1–2 years. We recognise the ambiguity of data sheet entries for many drugs used in child-
hood with respect to product licences and are aware that more than one phenothiazine drug was used at Birmingham Children’s Hospital for accepted clinical indications are used outside of assumed product license regulations (personal communication). However, the potential risks of administration of pro-
methazine to infants outweigh any possible therapeutic benefit and we therefore urge doctors, pharmacists, and parents to avoid its use in infancy.

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5 Stanton AN. Sudden infant death and phenoth-

Nasal instillation of ‘Olbas Oil’ in an infant

EDITOR,—Proprietary formulations of essen-
tial oils are readily available to the public for inhalation and are enjoying an increased popularity as natural remedies. Their toxicity when taken inappropriately by ingestion or nasal instillation is not generally appreciated. We report a case of nasal instilla-
tion.

Case history
A 4 month old boy had had four days of upper respiratory tract symptoms affecting feeding, and a relative had given his mother, a 30 year old woman with three other children, some ‘Olbas Oil’ without the box or instructions. She did not notice the warning against use in infants and put several drops in his right nostril. He immediately coughed, became achyphoric, and his colour deteriorated. An ambulance was summoned and he was brought into casualty.

On arrival he was peripherally cold with
Child resistant packaging and accidental child poisoning.

G Laing, M Thompson and S Logan

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