LETTERS TO THE EDITOR

Recurrent apparent life threatening events and intentional suffocation

Editor,—Intentional suffocation is a difficult diagnosis. Children often appear well in between such episodes and cannot tell their paediatrician that they are being intermittently assaulted. The evidence for intentional suffocation is often circumstantial, which means that doctors may have difficulty substantiating the diagnosis in court without evidence from covert video surveillance. We are surprised, therefore, that Davis et al state that a high proportion of suffocation victims were protected effectively without covert video surveillance. 1 It may be that these cases were not contested or had evidence of other harm to the child in addition to the suffocation.

Davis et al reinforced the British Paediatric Association working party guidelines that “when there is a very high risk, children should not be exposed to danger simply to achieve a criminal standard of proof.” Covert surveillance has been used in our knowledge primarily to confirm the diagnosis and to ensure effective protection for the child and siblings. Even in civil proceedings, which rely on a balance of probabilities, the more serious the allegations of abuse, the higher the level of evidence that is required. In a number of cases of suspected suffocation, we have seen children inadequately protected because of a lack of firm evidence from surveillance. Medical experts with little experience of suffocation may fail to convince a judge or concerned professionals of the necessity of cases of suffocation to have covert video surveillance evidence available. In our knowledge, there is genuine clinical uncertainty about whether the child is suffering “medical” life threatening events, or imposed ones, and where a careful review of the clinical history of the whole family will not support a diagnosis of fabricated illness. However, the fact that covert video surveillance revealed abuse in 33 of 39 suspected cases in Southall’s own report suggests that the clinical criteria used to select children for covert video surveillance were in fact good indicators of abuse in themselves.1 This work has been instrumental in bringing deliberate suffocation of children into the public domain and acknowledging that it is an important variety of child abuse. It has also clarified considerably the clinical elements of diagnosis. In light of these reports it is probable that covert video surveillance has become less necessary and a clinical diagnosis without it should now be more acceptable.

Covert video surveillance was used in only a quarter of the cases of non-accidental suffocation within the British Paediatric Surveillance Unit (BPSU) study. Of the 26 survivors of suffocation abuse followed up, all of them were initially protected by removal from the home or separation from the perpetrator. At follow up approximately two years later, only three of these 28 children had been allowed home without major conditions being applied (usually involving the exclusion of the perpetrator). Most of these children were subject to Care Orders.

Most of these children were, therefore, protected even though there was no evidence from covert video surveillance. Obviously, the follow up data supports the fact that we obtained our information from paediatricians means we can only draw limited conclusions about the risks of further abuse.

It was not our intention to suggest that clinicians were performing covert video surveillance purely to obtain evidence for a prosecution. However, the BPSU study and anecdotal experience suggest that where covert video surveillance evidence is available prosecution is more likely. We agree with Professor Soutball that prosecution has various benefits, but Children Act proceedings should allow the protection of children perfectly adequately in most cases. It is, of course, entirely appropriate for diagnoses of child abuse, clinical or otherwise, to be challenged in court. The complexity of cases of fabricated illness is such that only paediatricians with a major research background in this area should be undertaking these expert assessments. Courts seem, quite rightly, to be becoming more selective in this respect.

We agree that covert video surveillance requires specialist facilities and clinicians who are able to consider both unintentional and abuse diagnoses. However, we feel that many of these children can be diagnosed on clinical grounds and that not all infants suffering recurrent ALTE would need this service.


Rectal biopsy in the investigation of constipation

Editor,—Ghosh et al concluded that using rectal biopsy to investigate constipation and, thus, rule out Hirschsprung’s disease, is unnecessary if symptoms begin after the neonatal period.1 We agree with the authors that in most cases there is a history of constipation in the first month of life.

However, we saw two children recently whose symptoms began at four and five months old, respectively. They had suction rectal biopsy and were subsequently diagnosed with Hirschsprung’s disease, with excellent results after surgery. The parents were unable to provide a neonatal history. A Belgian review supports the view that symptoms can occur first after 1 month of age; they reported that constipation starts, on average, at 38 days.2 Thus, we feel that rectal biopsy may still be useful in atypical cases of infantile constipation.

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onset of symptoms was between 2 and 36 months (mean 7.5 months); this is not a new finding.1,2

Failure to perform biopsy samples in children with late onset of symptoms may delay the eventual diagnosis and could increase the risk of developing enterocolitis. We feel that the study from Southampton is a small cohort of patients with Hirschsprung’s disease and that the authors’ conclusion regarding the indication for rectal biopsy is incorrect.

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Infant feeding and atopic disease

Editor,—I was offended by David’s observation1 that many health professionals are “no more equipped to breast feed than they are to give practical advice on the subject” and that the middle class solution would be “close the door to the health visitor” and call in someone more appropriate.

Health visitors are skilled practitioners and, apart from during the initial 10 day period when midwives are still involved, do more work with new mothers to promote breast feeding than any other health professional, and are aware of the benefits of breast feeding to the infant and to the mother. However, in the postnatal period it is important that health visitors establish a long lasting professional relationship with the mother. We lose their favour, trust, and respect forever if we are forcing them to make decisions or to continue breast feeding when they are desperate to stop.

Contrary to David’s opinion, health visitors are not ill equipped to offer breast feeding advice. However, we work with the mother to help her adopt the type of feeding with which she is most comfortable. As a result, the mother may choose to change from breast to bottle feeding or, indeed, to mix the two types of feeding. Mothers are aware of the benefits of breast feeding to themselves and to the baby, but sometimes they prefer one type of feeding to another because it is more compatible with their lifestyle and commitments. As yet, I have had no success in helping a mother to continue breast feeding when she wants to stop, despite preparations made in antenatal classes.

It is unlikely that doctors will see mothers who feel they should breast feed even though they are frustrated by the baby’s demands, and despite the health visitor’s reassurance that it is normal to enjoy breast feeding almost constantly for long periods in the first weeks after the birth. These women may be exhausted and tearful and may admit to resenting their baby when it cries. All possible help and reassurance cannot persuade them to continue breast feeding, and they feel intense relief when they are given permission to introduce formula milk and, thus, the relationship between mother and baby instantly relaxes and improves.1

I feel strongly, as do many of my colleagues, that the most important factor in the first weeks after the birth is that the mother and baby enjoy each other. Therefore, the mother should be encouraged to breast feed if her desire to do so outweighs the pleasure of her baby. Mothers are aware of the long and short term benefits of breast feeding and feel immense guilt when they realise they want to stop. Who are we to make them feel even more guilty?

David should reconsider his comment that health visitors are worse than breast feeding counsellors,1 as the next best teacher is a woman who believes that she has had the best experience of childbirth or breast feeding and that others should adopt the procedures she found most suitable. It is a surprising comment for a doctor to make, as most health care professionals are familiar with the misconception that one should have had the condition oneself to be a good carer.

Dr David comments:

In reply to Ms Dion’s comments, the following points may be helpful:

The statement that some families opt for the support of—for example, a National Childbirth Trust trained breast feeding counsellor rather than the health visitor when seeking advice on breast feeding, does not imply criticism of health visitors. It is simply a factual observation.

It is well known that the quality of practical advice given to breastfeeding mothers by all types of health care professionals (including doctors, midwives, and health visitors) is highly variable and often very poor.1 This may be one reason why some mothers prefer to seek the help of non-health care professionals who fulfil the dual criteria of either having successfully breast fed their own infant or having received training in how to advise breast feeding mothers.

It is plainly unhelpful to try to force reluctant mothers to continue breast feeding, or to try to impose one’s own ideas as to what is correct.

Breast feeding does not equate with motherhood—nor are we practising what we preach.2

I fully agree that a mother who wishes to give up breast feeding should be allowed to do so, though I am saddened when I see this has happened largely as the result of simple problems that have been inadequately or incorrectly addressed by misinformed health professionals.3

Ms Dion says that mothers and babies who have one another are not ill equipped to give practical breast feeding advice, are a valuable resource in the training of health professionals.

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Albuniun: saint or sinner?

EDITOR,—I disagree with the conclusions of Nadel et al that albumin should remain the first choice as a resuscitation fluid in sepsis.1

The objections have been fairly highlighted by the authors:

- It is a blood product, which may carry an infection risk
- Blood products are in constant short supply
- It costs substantially more than stanch without any proven benefit towards the final patient outcome but with added risks
- Albumin is relatively impermeable to the endothelial barrier under normal conditions, it leaks relatively easily into tissues of critically ill patients.2

Clearly, trials are required to address this issue. Moreover, there is ample experimental and clinical evidence suggesting that hydroxyethyl starch (HES) of 250 kilodaltons (pentastarch) is more effective than albumin in reducing capillary permeability oedema in experimental and clinical models of permeability oedema.3

In addition, it has been suggested that the molecular size of the 250 kD HES is optimal for use in capillary leak and sepsis.4 It works not only because of its oncotic pressure but also because of its ability to seal and sepsis. The 250 kD HES has also been shown to have no adverse effect on clotting.5

Gelatins do not have the same virtues as albumin on cardiorespiratory function and effects of pentastarch and hydroxyethyl starch (HES) of 250 kilodaltons.6

It may be argued that a person who has had a single seizure is not epileptic and, therefore, does not need an EEG. However, the clinical usefulness of this definition should not be overemphasised. Epilepsy is a symptom of a number of different conditions whose only common feature is an increased susceptibility to seizures. This can be shown by the occurrence of recurrent seizures following the removal of an EEG abnormality. In the future, specific gene or ion channel defect may be the strongest predictor of a decreased threshold. An EEG should not be used to diagnose epilepsy, but its role lies in helping to determine which type of epilepsy the patient has.

A further argument about how to define epilepsy is often used to delay EEG examination. The practice of defining epilepsy as a condition that causes symptoms is experienced by epileptic seizures,7 it can be argued that a person who has had a single seizure is not epileptic and, therefore, does not need an EEG. However, the clinical usefulness of this definition should not be overemphasised. Epilepsy is a symptom of a number of different conditions whose only common feature is an increased susceptibility to seizures. This can be shown by the occurrence of recurrent seizures following the removal of an EEG abnormality. In the future, specific gene or ion channel defect may be the strongest predictor of a decreased threshold. An EEG should not be used to diagnose epilepsy, but its role lies in helping to determine which type of epilepsy the patient has.

A third argument for delaying EEG examination is the quality of EEG services. It is undoubtedly dangerous to rely on a poorly performed and incorrectly interpreted EEG. Is it safer to rely on such an EEG after a second seizure? This is an argument for improving services rather than an argument against adopting best practice.

There are few circumstances in which an EEG would be not appropriate when a child is considered to have had an epileptic seizure.

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References


Transitional care of young disabled people

EDITOR,—Fiorentino et al have tried to quantify the widely acknowledged view that the care of young disabled adolescents falling during their transition to adulthood.1 They have arrived rightly at conclusions which, when implemented, should improve transitional care of chronically disabled young people; this level of care has been delayed in its development by a lack of enthusiasm and initiative by health professionals and their organisational bodies. Furthermore, a significant number of young people with chronic health problems do not have a “statement of special educational needs”.

Last year, I presented findings of a survey of transitional care of chronically ill young people in the South Thames region at a national meeting of community paediatricians.2 This was a questionnaire-based, and 161 practising paediatricians and consultant child psychiatrists from the South Thames region took part. The questions dealt with the current level of satisfaction with transitional care and planned changes in this area as perceived by the participants. The data showed that while only 32% were either frequently or always satisfied with the current transitional care for disabled adolescents, only 90% were always looking towards changing the situation. The lack of equivalent adult services were cited frequently as an unmet need.

Recently, the UK Royal College of Physicians3 and the American Academy of Pediatrics4 issued guidance in the organisation of transitional care. We should therefore take this opportunity to persuade the Department of Health and primary care groups to provide organised transitional care for disabled young people. During the past 20 years, the survival of young chronically ill people has improved greatly due to the dedication of, and hard work by, carers as well as health professionals. It would be a disservice to these young people and their carers if we fail to improve service provision during their transition to adulthood.

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References


EEG and epilepsy

EDITOR,—We welcome the debate on the timing of EEG examinations.1 The practice of delaying the EEG until after a second seizure began when epilepsy syndromes were unrecognised. The EEG was then of little help in predicting prognosis or guiding treatment, but has been transformed by the recognition of epilepsy syndromes. Although some of these syndromes may be difficult to diagnose, other epilepsies, benign childhood epilepsy with centroparietal spikes, and juvenile myoclonic epilepsy, have easily recognised clinical and EEG features.2 It may not be possible to predict seizure recurrence in a child who has had a nocturnal tonic


Attention deficit hyperactivity disorder

EDITOR,—In the management section of his paper on attention deficit hyperactivity disorder (ADHD) which focuses mainly on medication,1 Hill gives the erroneous impression that managing hyperactivity in the classroom is difficult and ineffective: those who use it regularly to control ADHD know that this is not the case.

Standard diets are not helpful in the management of this disorder because the foods which provoke hyperactive behaviour are different for each child. Few parents succeed in identifying the foods which affect their child without help, but an elimination diet is effective in most cases. Deficiencies of omega-6 essential fatty acids are common in these children2 so, in addition to the calcium supplement given to all children avoiding milk, evening primrose oil, borage oil, and cofactors such as zinc, are also usually

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many of these children other conditions—for example, glue ear or eaten too frequently. The diet may relieve which cause a distinct deterioration in behav-
socially if eaten frequently. An improvement is any food may provoke hyperactivity, espe-
cially if eaten frequently. However, reactions to cheese, wheat, and other fruit are also common and any food may provoke hyperactivity, espe-
cially if eaten frequently. An improvement is often seen in children within 3–7 days, and single open oral challenges are usually sufficient if given within three weeks. Foods which cause a distinct deterioration in behav-iour should be avoided for several months, by which time they can often be tolerated if not entirely. The diet may have other conditions—for example, glue ear or abdominal pain, which are also present in many of these children1; in boys with eczema it is sensible to arrange challenges under supervision as there have been reports of anaphylaxis. Finally, the nutritional quality of longer term diets should be checked by a dietician.

If the diet is effective, behaviour often reverts to normal, to the great relief of all concerned. In view of the potential toxicity of medication in children and its limited effec-
tiveness, all families with hyperactive children should be offered help in detecting offending foods. It is more appropriate to reserve medi-
cation for those who fail.

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2 Stevens LJ, Zennali SS, Deck JL et al. Essential fatty acid metabolism in boys with attention-

4 Carter CM, Urbanowicz M, Hemmley R, et al. Effects of few food diets on hyperactivity and attention deficit dis-
5 Boris M, Mandel PS. Foods and additivess are common causes of the attention deficit hyper-

Professor Till comments:

Of course an elimination diet works for some children with attention deficit hyperactivity disorder; I use it myself. I agree that there is good evidence of the effectiveness of the few-food diet, but its effect size is small com-
pared with that of medication. Parents committed to dietary treatment have usually tried it. Those who are uncommitted may find it cumbersome. I know of no convincing hard evidence that confirms an allergic mechanism. The approach recommended by your participants is a mixture of elimination diets, additive restriction, and magic ingredi-
ents, which I fear has not been tested scientifically. Nevertheless, I expect that bor-
age oil is very nice.

Doctors as expert witnesses

Ennor,—Most doctors do not like giving evidence in court, and giving an opinion is becoming more difficult as advocates appear to be increasingly hostile, and judges non-
terventional. As care courts have become more adversarial it may be easier to appear as a witness in the criminal court where the rules of evidence are clear. Following the Children Act 1989 the emphasis was to be inquisitorial with “...the child’s welfare is paramount” as the fundamental tenet.

Contrary to this concept of the Children Act a group of doctors exist who do not appreciate the need to give evidence in an even handed way and to give all the evidence without omissions (Re AB1 and Re B2). The Expert Witness Group1 was estab-
lished to make doctors’ credentials clear, their training, practice, and research interest. A standard form is available to the courts which clarifies the doctor’s expertise.

The pretrial meetings in care proceedings aim to clarify and simplify medical opinion to smooth the legal proceedings and “reduce or obviate the need to attend court”. A schedule of agreement and disagreement is drawn up, there may be no significant differences of opinion yet the doctors are still called to court. Why meet, won’t others? There is a debate as to whether court should hear these meetings (I do not know any practising doctor with the time and secretarial back up to undertake this work).

It is galling that the courts take doctors’ time so casually; often spending hours in the witness box—or often far longer with the child and family. What can be done?

• the full implementation of the Pigot report would allow more children to be heard in criminal proceedings
• universal introduction of the Expert Wit-
ness Group’s form would clarify the expertise of witnesses
• pretrial liaison is useful but only if there is a reduction in doctors’ hours in court
• referral of more cases to lower courts to be heard by appropriately trained magistrates
• more joint training between paediatricians and advocates (at all levels).

With more discussion and training paedia-
tricians will become better advocates for chil-
dren.

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Pretrial liaison between doctors in alleged child abuse

EDITOR,—We were interested in the annota-
tion on pretrial or precourt hearing liaison between doctors acting as expert witnesses in the cases of alleged child abuse.2 We agree that there is considerable uncertainty in this approach as the following case illustrates.

A set of female triplets were initially referred to one of us (DH) for review and examination following a disturbance that had been sexually abused by their father. The children were examined by colposcopy using a standard technique of gentle labial traction.3 Still photographs of the findings were made with the informed consent of the mother who understood that they would be used for teaching and training purposes only. The examination findings were consistent with previous sexual abuse, but there was neither disclosure of, nor findings compatible with, recent trauma.

The photographs were subsequently ob-
tained and discussed at a peer group review meeting held by North East London paedia-
tricians who work in child protection at which we were present. There was a debate as to whether there were changes in the hymens of the triplets consistent with sexual abuse or whether the changes were due to genital abnormalities of the hymen. Un-
known to the peer group members, one of us (JW) had been asked by the official solicitor to review the medical evidence.

To resolve these important issues it was agreed that there should be a joint medical examination by DH who described the initial findings, JW who had been asked by the offi-
cial solicitor to comment on the medical report, and VL who gave an independent opinion. The mother and children gave consent. The court granted permission for the medical to be part of a “precourt” review. At the examination we agreed that in two girls the findings were diagnostic of sexual abuse or in the third strongly supportive of it. No doctor had to give evidence in court.

These cases illustrate three points. First, the utility of the peer group review; second, the difficulties that may arise when photo-
graphic or even video evidence is used; and third, the positive benefit of joint examination by experienced paediatricians. None of the girls reacted adversely to the process and we were able to discuss the findings with the family and other child protection agencies.

We believe that this case highlights the importance of pretrial liaison in child protec-
tion work and illustrates the therapeutic ben-
efit of the joint approach.1

DEBORAH HODES

1 1 FLR 181.
Currently more than 300 children have been enrolled worldwide in an international multicentre randomised trial of bactericidal permeability increasing protein in severe meningococcaemia. To gain the maximum benefit from the huge amount of data collected, ongoing registration is required between clinical trials. The formation of a central coordinating group is long overdue.

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Is prolonged rotavirus infection a common cause of protracted diarrhoea?

EDITOR,—The possible link between rotavirus and the postenteritis syndrome was highlighted in the recent editorial1 about Richard-son et al's paper concerning the finding of prolonged rotavirus excretion in the stool using reverse transcription–polymerase chain reaction.2 We believe it is important to be circumspect about this link as the evidence to date is circumstantial.

The symptom duration in Richardson et al's study ranged up to but not beyond, 4 days. This is at the minimum limit for diagnosing persistent diarrhoea.3 Following this there were only two intermittent episodes of mild diarrhoea and/or vomiting in three children, one episode in five, and no episode in three of the cases who were shown to have rotavirus RNA in their stool for > 21 days after the onset of severe rotavirus diarrhoea. A comprehensive screen for other pathogens was not carried out, so infection by another agent cannot be excluded. No growth was obtained in MA104 cells so that the viability of the stool rotavirus could not be established, and the finding may represent the excretion of degenerate particles. A stronger case would be made if rotavirus had been found in the mucosa of children who had protracted diarrhoea at the time and who had prolonged excretion of rotavirus, as shown in the classic paper of Bishop et al.4 Extended stool excretion, in the absence of clinical symptoms, has been shown for rotavirus and other gastrointestinal viruses5 and this may be a common phenomenon in viral gastroenteritis, just as excretion of pathogenic bacteria in asymptomatic individuals (the carrier state) is recognised. This is a potentially important observation in terms of cross infection, but not necessarily in terms of chronic, postenteritis diarrhoea.

Our retrospective analysis of cases of the postenteritis syndrome in a hospital setting6 has shown intermittent viral infection and persistent bacterial infection to be important associations with the diagnosis, and our earlier report of degenerate rotavirus particles in the stool of two children with protracted diarrhoea using electron microscopy7 probably represents nonviral infection rather than persistent rotavirus infection. While it may be tempting to conclude that rotavirus can cause the postenteritis syndrome, the evidence presented to date does not make it more than a hypothesis awaiting rigorous examination.

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CMV coinfection and disease progression in vertically acquired HIV infection

EDITOR,—The paper by Boriskin and colleagues provides interesting information regarding the age related contribution of cytomegalovirus (CMV) viral load in HIV infected children. The significantly higher CMV viral load in the youngest age group (0–2 years) could explain the generally higher mortality in this age group due to the accelerated disease progression.8 However, the conclusion regarding the progression of HIV infection associated with the CMV viral load in this cross sectional study should be treated with caution.

Between May 1985 and September 1995 we were able to follow from birth 25 vertically infected children in our hospital setting. Between May 1985 and September 1995 we were able to follow from birth 25 vertically infected children in our hospital setting.
EDITOR,—Heat stroke is a potentially fatal disorder but often difficult to diagnose in children. Peripheral neutrophils with radially hypersegmented nuclei—"botryoid" neutrophils—are known to be characteristic of heat stroke in adults.1 We describe three children exhibiting botryoid neutrophils who presented with acute encephalopathy.

Patient 1 was a 7 month old girl with severe central hypotonia who became unresponsive and after being kept warm with a hot pack in winter. She was febrile (≥ 42°C) and hypotensive, and she had several seizures and bloody stools. After supportive treatment including cooling procedures, she returned completely to her pre-illness state 14 days later.

Patient 2, a previously healthy 9 year old girl with a one day history of cough and fever was found unresponsive and convulsive in winter. Before her collapse, her mother had kept her warm with an electric foot warmer because she had complained of a chill. Her clinical picture was characterised by high fever, (≥ 42°C), shock, diarrhoea, and bleedings. Despite aggressive treatment she continued to deteriorate and was pronounced brain dead on day 4.

Patient 3 was a previously healthy 14 month old boy with a three day history of diarrhoea who presented with acute encephalopathy in summer. He had been well until three hours earlier. At presentation his temperature was 40.4°C and his blood pressure 36 mm Hg. Bleeding diathesis was outstanding on his skin and oral mucosa.

Botryoid neutrophils in unexpected heat stroke

Despite aggressive resuscitative measures he died 18 hours later.

Table 1 Laboratory findings of patients exhibiting botryoid neutrophils during acute stage

<table>
<thead>
<tr>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
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<tr>
<td>Leucocytes (×10⁹/l)</td>
<td>7.3</td>
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<td>Neutrophils (×10⁹/l)</td>
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<td>108*</td>
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</table>

*Fell by more than 30 g/l within 3 days after onset.

Figure 1 Peripheral neutrophil with radially hypersegmented nucleus (botryoid neutrophil) observed at admission. (A) patient 1; (B) patient 2; (C) patient 3. (Original magnification ×1000, May-Grünwald-Giemsa staining.)

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3 Neves JR, Lopes D, Casal MI, et al. "Botryoid" nuclei of leukocytes in the haemorrhagic forms of HSES. Heat stroke may easily be misdiagnosed as infectious encephalopathy because children, as with patients 2 and 3, frequently have clinical evidence of infection.

Our observations suggest that detection of botryoid neutrophils may be helpful in the early diagnosis of heat stroke including atypical HSES in children who present with acute encephalopathy.

1 Pleskoff et al. showed that CMV encodes a chemokine receptor, which also serves as a co-factor for the entry of HIV into cells.1 Furthermore, CMV is able to potentiate cellular immunodeficiency in HIV infection directly or due to coinfection with enhancement of HIV replication.3 Therefore, a longitudinal study should be performed using CMV viral load to estimate the correlation of HIV and CMV coinfection for disease progression.

The diagnosis of haemophilia in a newborn son often leaves parents feeling completely overwhelmed. Many mistakenly believe that a simple scratch in a boy with this congenital bleeding disorder can lead to death through exsanguination, or that their son will end up in a wheelchair because of early arthritis. In fact, the prognosis for young people with haemophilia is excellent, and boys in developed countries can look forward to an essentially normal life. Haemophilia actually confers protection against coronary artery thrombosis, which is the principal cause of death in middle aged men.

Haemophilia is a relatively rare disorder, affecting approximately 6000 boys and men in the UK. Few doctors and nurses will have experience of dealing with a condition that affects only 1 in 10,000, and parents may be frustrated by difficulty in finding answers to their many questions. This book distils the personal experience of a paediatrician, which extends over 30 years, in the treatment of this rare disorder. The book is primarily aimed at the parents of boys with haemophilia. However, it will undoubtedly also be an invaluable source of reference for all health care professionals or others (such as teachers) who come across children with haemophilia. The value of this book is reflected in the fact that the introduction of recombinant coagulation factor concentrates has resulted in staccato, one word sentences in the comments section. This approach can occasionally be quite confusing and assumes a rapid understanding of the subsequent text. The tables are simply laid out, contain a sensible amount of information, and are easy to sift through. Overall, this is an excellent book. The authors and publishers are to be congratulated for a number of reasons. The English translation is virtually faultless, the images excellent (always hard to achieve with plain radiographs), and the general layout is easy to follow. The aim of the book is an aid to differential diagnosis when confronted with a radiological finding in a child, although the major strength is really in the large selection of good quality plain films and other images.

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The author of this latest addition to the Epynymata in medicine series is a distinguished Irish professor of paediatrics, well known for his interest in mental handicap. He has been honorary medical advisor to the Down Syndrome Association of Ireland for 20 years. Conor Ward is to be congratulated on this first full and vivid biography of a remarkable and somewhat neglected Victorian physician.

John Langdon Down, MD, FRCP was born in Cornwall in 1828, the son of an apothecary. Entering medicine in 1853 he was a brilliant student and qualified at the University of London in 1858. At once he was appointed superintendent to the Royal Earlswood Asylum for Idiots. Careful observation and the use of clinical photography enabled him to attempt a classification of children with mental retardation. He was the first to describe both the Prader–Willi syndrome and, in 1866, the characteristics of mongoloid idiocy, which, 95 years later, came to be known eponymously as Down’s syndrome.

In 1868 Langdon Down opened his own private institution for mentally retarded children, Normansfield. There he worked till his sudden death at the age of 68 in 1896. His work was then continued by his sons Reginald and Percival, and by a grandson, until the institution was absorbed into the National Health Service in 1952.

Langdon Down was a large handsome man with charming manners and liberal views. A pioneer in the humane caring for and treatment of people with learning disabilities, he had a natural empathy with the handicapped. In this as in other ways he was ahead of his time. He was a strong advocate for the rights of women and for their higher education. He became a Justice of the Peace and in 1889 Alderman for Middlesex.

This slim volume is well illustrated, referenced, and indexed. It is warmly recommended to all those having an interest in the history of medicine and in the care of those with mental retardation.

P M DUNN
Professor of Perinatal Medicine and Child Health


The evidence provided by the diabetes control and complications trial (DCCT) exerts considerable pressure on clinicians to help their patients achieve optimal blood glucose control. This book has been written to provide detailed information for primary care physicians who, due to shifting responsibilities in the USA away from specialist teams, are becoming increasingly involved with the care of children with diabetes.

Initially, the book appears rather wordy, having few diagrams and no pictures. However, it is not always the books with the most lavish illustrations that prove most use to the novice learning a craft. This book, while not forgetting some scientific information, is about the practical aspects of managing childhood diabetes. It is written in a sensitive manner, is easy to read, and the many brief case studies provide useful and interesting verbal illustrations. I was glad to find that, despite the transatlantic differences, we share a common philosophy of care, and most of the subject matter is as relevant in the UK as in the States. Professor Plotnick’s empathy with the children and their families is evident throughout the book, and social and psychological issues feature alongside the day to day diabetes management. There are chapters by a dietitian and nurse educator, and an appendix that contains a variety of sample record forms and letters, a reading list, and web sites.

I get the impression that American families are encouraged to work harder at perfecting their diabetes management than their British counterparts, although it was sobering to note that personal finances and insurance policies may restrict some families’ ability to do this. Much is expected of them especially where meal plans and monitoring are concerned. Detailed instructions are given for altering insulin doses, and intensive monitoring and accurate record keeping are emphasised to achieve good control. I was intrigued to learn that when blood glucose concentrations are out of target range it is possible to determine the decrease of blood glucose produced by one unit of insulin by using “the 1500 rule”. This entails dividing 1500 by the total daily dose of insulin to calculate how many mg/dl one unit of insulin will decrease blood glucose.

The Diabetes nurse educators appear to work in much the same way as specialist nurses in the UK; however, I would have liked to learn more about their teaching methods and aids with perhaps some illustrations. It was interesting to see a whole page devoted to drawings of different sizes of syringes and needles but none of pen devices that are “very popular in Europe” or pumps, which are used more by American children.

This book will be of interest to all practical clinicians caring for children with diabetes, but more will be gained by reading it in its entirety before delving for specific information. Some phrases remain in my mind which could sum up its ethos: “thinking like a pancreas”, the “relentlessness of diabetes” and “keeping hope alive”.

SALLY STRANG
Paediatric diabetes specialist nurse

Data Interpretation in Paediatrics.


The written paper of the MRCPCH part II examination (member of the Royal College of Paediatrics and Child Health) consists of three sections: case histories or “grey cases”, visual material, and data interpretation.

The current market boasts a multitude of excellent reference atlases and examination orientated picture books that between them offer a staggering array of clinical photographs. Conversely, there are only several challenging books of case histories and, as yet, even fewer texts for data interpretation. Although practice promises to make perfect, this is perhaps a more realistic target to attain in the analysis of data questions than in answering the case history section, which does tend to retain a murky quality peculiar to itself. This book will certainly aid one in developing a critical approach to data problems, and the importance of achieving confidence and maximum scores in this section cannot be over emphasised in an examination which, so often, is lamentably unpredictable.

The questions in this book cover a broad spectrum of topics and manage to include problems referring to recently implemented investigative techniques in medicine as well as to conventional “bedside tests”, of which few junior doctors these days have actual clinical experience. In recent years there has been a growing representation of neonatology questions in the examination as well as the increasing employment of figurative data in the form of EEGs and ECGs, and the complex numerical data of cardiac catheter measurements and pulmonary function tests. These trends are adequately reflected by the choice of questions in this book. Subjects such as epidemiology and genetics, which are all too frequent stumbling blocks, are addressed in a comprehensive manner.

The overall standard of questions is comparable to that faced in the actual part II examination and the answers are succinct with appropriate references to the standard paediatric textbooks. Thankfully, it avoids making the common error committed by many textbooks for postgraduate qualifications, which aspire to be so difficult and esoteric that one loses all faith in one’s ability ever to pass the examination.

Furthermore, Data interpretation fits snugly into a jacket pocket, making it a handy companion on train journeys or for quiet moments on call when revision beckons.

Having recently sat, and fortunately passed, the MRCPCH part II examination I would thoroughly recommend this book to potential candidates. It is one of the few question books that I had the time and the heart to reread just before the examination in that critical period when one needs to revise material in the shortest possible time while simultaneously suppressing an ever growing sense of panic.

Finally, I believe that this is a useful text even for those who have left the spectre of postgraduate examinations far behind. I am sure that a surprising number of new facts may be gleaned from perusing these pages and, after all, the process of self education by no means ends with membership.

SHARMILLA DIAS
Recurrent apparent life threatening events and intentional suffocation

M P SAMUELS and D SOUTHALL

Arch Dis Child 1999 81: 189
doi: 10.1136/adc.81.2.189

Updated information and services can be found at: http://adc.bmj.com/content/81/2/189.1

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