LETTERS TO THE EDITOR

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Palivizumab and RSV prevention

EDITOR.—The letters from Drs Deshpande and Nicholl, in relation to the Impact-RSV study and the UK guidance for the use of palivizumab in the prevention of serious RSV infections, raise interesting questions that need addressing.

I believe Dr Deshpande “has got it wrong” in that he fails to realise that the primary objective of the IMPACT study was to investigate whether palivizumab reduced RSV hospitalisations in high risk infants.

It was never intended that this study would address the severity of RSV infections, the need for paediatric intensive care, the need for mechanical ventilation, or a reduction in disease. It is unreasonable to suggest that because the study didn’t show these then it is not valid. To show such benefits would require a totally different protocol, the numbers of patients being such that the study could never have been undertaken.

To reiterate the findings of the IMPACT study, there was a 55% reduction in hospital admission rate for RSV proven disease—a significant result, however one wishes to interpret it. Those high risk patients admitted with RSV infection spent fewer days in hospital, had less need for oxygen treatment, and had lower respiratory infection clinical scores if they received palivizumab.

The study was designed in association with and with the approval of the licensing authorities to grant a marketing licence for the medication. It was not designed to provide economic data on the cost effectiveness of the product. Both Deshpande and Nicholl fail to realise that if they want this information then different studies are needed.

Does anyone know the lifelong cost of RSV disease in infancy? What is the relationship between RSV hospitalisation in the first year of life, recurrent wheezing in childhood, or indeed the possible development of chronic obstructive pulmonary disease in later adult life? To develop a relevant, long term, cost effectiveness plan, all these points need to be taken into consideration. In an attempt to help with this there are two ongoing studies that Deshpande, Nicholl, and others, may find helpful. One is taking place in four centres in the UK and the other is a follow up study from the IMPACT trial. Both are attempting to identify risk factors and costs over a three year period following hospitalisation for RSV disease, and it is hoped the results will be available later on this year.

The UK guidance on the use of palivizumab does not advocate universal usage of the product, but makes recommendations on how infants may benefit. It is the role of clinicians in local hospitals to discuss with their managers, the local health authority, and the individual primary care group or trust, which specific patients they feel should receive palivizumab. These decisions may well differ between centres depending on budgets, the morbidity of their patients and interpretations of evidence both research and clinical.

RSV bronchiolitis remains the greatest annual epidemic disease to hit paediatric departments in Europe, the USA, and Australasia. The treatment of the symptoms is unsatisfactory in that the only proven benefit is oxygen. Each year, vast amounts of money are wasted on bronchodilators, steroids, ipratropium bromide, and antibiotics. Palivizumab, the first monoclonal antibody to be developed specifically for use in paediatrics, has been shown to be effective in reducing hospital admission in high risk infants. To dismiss it out of hand seems churlish. To rationalise its use in those whom it may most benefit seems clinically sensible. All new treatments should be considered with caution. However, I believe that if clinicians take a back seat view whilst awaiting definitive confirmation of absolute cost effectiveness, we will continue to deny our most vulnerable patients the benefits of scientific advance.

WARREN LENNEY
Academic Department of Child Health, City General Hospital, Newcastle Road, Stoke-on-Trent ST4 6QG, UK


EDITOR.—I am writing in reply to the recent correspondence regarding the use of palivizumab (Synagis),1,2 a monoclonal antibody licensed for the prophylaxis of respiratory syncytial virus (RSV) infection in premature infants. RSV is a disease that affects 50% to 70% of all infants within the first year of life, and causes significant morbidity and mortality, particularly in a number of well defined high risk groups.

The major trial demonstrating the safety and efficacy of palivizumab (Synagis)1,2,11 a randomised, double blind, placebo controlled, multicentre trial that enrolled 1502 children with prematurity (≤35 weeks gestation) or bronchopulmonary dysplasia (BPD). One hundred and twenty three of the children enrolled were from 11 UK centres. The primary end point of the IMPACT-RSV study was hospitalisation due to confirmed RSV disease. The study was not powered to demonstrate a reduction in mortality, neither was it designed as a pharmaco-economic study. The average gestation of all the infants was 29 weeks and the placebo (n=500) and palivizumab (n=1002) groups were well matched for both demographic parameters and RSV risk factors. The study demonstrated a relative reduction in RSV related hospitalisation of 55% (10.6% placebo v 4.8% palivizumab p=0.0004). A significant reduction in RSV hospitalisation was seen irrespective of gestational age, diagnosis of BPD, and gender. Of all the children in both groups admitted with RSV infection, 27.7% were admitted to intensive treatment units (this figure was similar in both groups). There was however a significant reduction in the overall incidence of RSV related intensive treatment unit admission in the palivizumab group (3% placebo v 1.3% palivizumab p=0.026).

The placebo RSV hospitalisation rate of 10.6% reported in the IMPACT-RSV trial was lower than that seen in previous controlled trials which have reported rates of 13.5%,2,10,12 20%,2,12,13 22.4%,2,12,13 and 37%. Further reported rates of hospitalisation vary depending on the risk group studied, and data from the US demonstrate that it is possible to predict subgroups who have considerably higher hospitalisation rates.2 Further data from both Europe2,14 and the US11 reported RSV readmission rates in large numbers of premature children receiving palivizumab prophylaxis over the 1998/9 RSV season (neither study had a placebo arm). Of the 586 European infants enrolled, 1.2% had confirmed RSV hospitalisation, whilst two US groups of 1839 and 7013 children had RSV hospitalisation rates of 2.3% and 1.5% respectively. Despite the lack of comparator arms, these data do suggest that the IMPACT-RSV trial may have underestimated the true efficacy of palivizumab.

The generation of pharmaco-economic arguments directly from the IMPACT-RSV data is a much oversimplifies what is an extremely complex issue. Hospitalisation rates vary considerably between risk groups, and measuring the true economic cost of RSV hospitalisation requires long term follow up, both of hospital, community, and parental costs.

Despite its relatively high costs, modern neonatal care has led to dramatic improvements in the outlook of premature infants. Advances such as surfactant therapy and mechanical ventilation seem expensive on the face of it, but both controlled trials11 and clinical experience have shown the investment to be worthwhile.

Dr Deshpande refers to the guidance document reflecting the outcome of a consensus committee of a number of UK clinicians,3 and issued by ourselves. Many were aware of the guidelines published by the American Academy of Pediatrics regarding RSV prophylaxis and the use of palivizumab,4 and felt that whilst they were very useful, UK guidelines should be formulated at a local level, taking into account local risk groups and epidemiology. For these reasons, the UK guidance document deliberately avoids being too prescriptive and whilst describing the two major risk groups (premature infants; ≤35 weeks gestation, and those with BPD), it emphasises that treatment priorities are likely to vary locally and that decisions regarding which preterm infants to treat will be individualised.

Abbott Laboratories are continuing to work with many in the paediatric community in order to help better define many of the issues. We strongly feel that palivizumab is an important breakthrough in the battle against RSV infection, a disease that continues to...
cause high levels of morbidity and significant mortality in high risk infants.

CHRISTINA CARNEGIE
Medical Director,
Abbott Laboratories Ltd, UK


The editor comments:

In her letter, Dr Carnegie refers to a guidance document reflecting the outcome of a consensus conference of a number of UK clinicians and issued by Abbott Laboratories Ltd.

Earlier this year, we received as a submission for publication such a document, headed by the names of a number of distinguished paediatricians and neonatologists. I was puzzled because it was addressed from a public relations company. I contacted all those named to ask who the corresponding author was. I learned that they did not know the paper was to be submitted to a peer reviewed journal.

Consequently, I invited the PR company to withdraw the submission, which they did. The paper, itself, was marked as having been produced with the aid of an educational grant from Abbott Laboratories.

In general, Editor of Disease in Childhood is reluctant to publish the results of consensus groups, unless the methods by which they arrived at their conclusions are totally transparent. This case illustrates one reason why we believe it is right to be cautious.

HARVEY MARCOVITCH
Editor in Chief

Dietary products used in infants for treatment and prevention of food allergy

EDITOR,—The joint statement of the European Society for Paediatric Allergology and Clinical Immunology (ESCAPCI) and the European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN),1 deserves some comment.

Firstly, on the use of soy based formulas for the treatment, as well as for the prevention of food allergy: I was disappointed that no word about this subject appeared in the conclusions of the statement. Many have claimed that the use of soy bean formulas in infancy is an efficient way of preventing food allergic disorders, but more recent prospective and randomised clinical studies have shown that soy protein is as allergenic as cow’s milk protein.2 As the matter remains controversial, I believe that the conclusions should have been that soy based formulas are not recommended for the treatment or prevention of food allergy until more data are available.

The second issue concerns the use of partially hydrolysed formulas for preventing food allergy. A recent five year follow up prospective, randomised, and controlled study by Chandra,3 which showed a beneficial preventative effect of a partially hydrolysed formula in high risk infants, was ignored. The only study where the preventive effect of an extensively hydrolysed formula was compared with the use of a partially hydrolysed one, showed that the former was superior to the second.4 This paper, however, has a possible methodological shortcoming: the manufacturer (Mead Johnson, Evansville, Indiana, USA) provided both a commercially available, extensively hydrolysed formula (Nutramigen) and a non-commercially available (at least in Sweden where the study was undertaken) partially hydrolysed formula, prepared by mild (heating?) enzymatic hydrolysis. In future, such studies should only use commercially available formulas of either the same or different brands. I consider that current data are insufficient to allow a firm view. Therefore, I believe the conclusions should have stated that no clear recommendation can be made for the use of a partially hydrolysed formula to prevent food allergy.

Conclusions of consensus statements are generally considered as guidelines for the practitioner. Omissions, as in the case of soy based formulas, or ambiguities, as in the case of partially hydrolysed formulas, do not clarify the issues so should be avoided. I believe that modified conclusions, as referred to above, would have been more in agreement with the literature and more helpful to the reader.


Dr Koletzko and Host comment:

We thank Professor Salazar-de-Sousa for his insightful comments on the joint comment of ESPACI and ESPGHAN.

We kept our conclusions brief and did not repeat all the considerations discussed earlier in the text but, rather, focused on the practically most relevant advisable measures to treat and prevent food allergy. In the text of the comment it is stated that, based on information currently available, we do not recommend the use of soy protein based formulas as a first line choice to prevent food allergy in infants. However, we also noted that different views exist on this issue and that further studies may be useful to extend the rather limited database available, in order to clarify the allergenicity of soy formulas in infants with allergy risks.

The data presented in one of the studies by Chandra referred to by Professor Salazar-de-Sousa were not ignored. However the comments felt that neither paper nor many similar studies allowed definitive conclusions on all the issues. Since our comment was not intended to be an extensive review of all available publications, we did not cite this particular paper or the many other original papers on this topic, but referred to a recent editorial considering these and other data.

We agree with Professor Salazar-de-Sousa that currently available data are insufficient to allow a firm conclusion on the relative effects of partially versus extensively hydrolysed formulas for the prevention of food allergy, an important issue for clinical practice. Hence, we concluded that more studies are needed.

1 J SALAZAR-DE-SOUSA
Professor of Paediatrics,
Ana de Republica, 64-6, 1050.197 Lisbon, Portugal

Health care needs for travellers

EDITOR,—The article recently published by van Cleemput has made a valuable contribution to the health care needs of travellers and has drawn attention to a very deprived section of our community.1 However, the assertion that childhood asthma is more common in travellers is not based on sound evidence. This suggestion was based on a study by Anderson, who reported on the health concerns and needs of traveller families.2 The selection criterion for Anderson’s study was families with children of less than 5 years of age. The traveller families had a mean of six children aged 1 to 15 years. The control

1 ARNE HOST
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University of Odense, Denmark
Chair, ESPACI Committee on Hypoallergenic Formulas


the travelling lifestyle may be a protective
*p = 0.04). We concluded that the experience of
B6 deficiency is not common in man.

have a suboptimal intake with or without
Fits, pyridoxine, and hyperprolinaemia

traveller schoolboys. The values were signifi-

in schoolboys from the control group than in

The parent reported prevalence of wheezing

11% of inner city families and 4.5% of a

4 years. Anderson reported that asthma was a

a diagnosed asthma (25.6% ≤ 11.1%, OR = 1.1, p = 0.04). We concluded that the experience of

child with an autosomal recessively inherited

1-pyrroline-5-carboxylate dehydrogenase

These (sub)clinical deficiencies can

It would be interesting to know

LHRH analogue and growth hormone
did not improve the final height of a patient
with juvenile hypothyroidism accompanied by precocious puberty

EDITOR.—We report an 11 years 8 months old
girl with juvenile hypothyroidism and preco-
cious puberty who failed to respond to
thyroxine, growth hormone, and luteinising hormone releasing hormone (LHRH) ana-
logue. The patient was considered to be
hypothyroid for about two years before the
therapy was started. She had a very low
serum thyroxine concentration, a height SD
score of −3 SD, and a bone age of 10 years 3
months. Her pubertal development was
graded as Tanner stage IV of breasts and
Tanner stage II of pubic hair. Her menarche
occurred at the age of 10 years 3 months. The
enlarged pituitary gland reduced in size with
the thyroxine treatment (100 μg/day). In
addition to thyroxine, she was treated for 31
months with an LHRH analogue (30 μg/kg,
one a month) and growth hormone (0.5
U/kg/wk divided into six doses) to avoid the
progression of puberty and improve the final
height. She reached the final height at the age
of 15 years 1 month (~2.8 SD), which was the
same as the before the treatment (fig 1).

Minamitani et al reported that treatment
with LHRH analogue and growth hormone
in addition to thyroxine was successful in
improving the final height and avoiding
pubertal growth of patients with juvenile
hypothyroidism in the prepubertal stage.1
Difference between the report of Minamitani
et al and our case is that our patient already
had the advanced bone age relative to height
age and the progression of puberty at the start
of treatment, to which our failure to improve
the final height with the combination therapy
might have been ascribed. To improve the
final height, we should have increased the
dose of LHRH analogue and growth hor-
mon. During the combination therapy, peak
serum insulin like growth factor 1 was 710
ng/ml (normal: 370–896 ng/ml), and peak
concentrations of LH and FSH were com-
pletely suppressed in response to gonadotro-
in releasing hormone analogues. Although her men-
struation was successfully suppressed, bone
maturation was not inhibited.

We concluded that patients with juvenile
hypothyroidism who are often found to be
in progressive pubertal development may not be
indicated for treatment with LHRH analogue
and growth hormone. An early diagnosis may
therefore be of utmost importance in improv-
ing the final height. In Japan, schoolchildren
are biannually measured for height and
weight. It is therefore strongly urged to
educate school nurses to direct their attention
to the evaluation of height measurements and
also to arch and to consult paediatric
endocrinologists. Although a number of pos-
sibilities have been raised for failure in attain-
ment of desired height in the patient, the early
medical attention would have been expected
to lead to the possible prevention of short
 stature.

This work was supported by grants from the Minis-
try of Health and Welfare of Japan, the Ministry of
Education, Science, and Culture, the Japan Private
School Promotion Foundation, and the Mami
Mintzun Foundation.

Rika Miyazaki
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Intraosseous access in infant resuscitation

EDITOR.—We believe that intraosseous access
to the circulation in infant resuscitation is
derundervalued and therefore under utilised.
Intraosseous cannulation is easy and effective
technique that can be performed both quickly and safely in resuscitation.1,4
There have been relatively few complications
reported with this technique.1
In a laboratory study, we compared the
average flow rates through a range of
intravenous cannulae with that of an 18 gauge
intravenous cannula. We purged intravenous
Hartmann’s solution through the various
devices, at a constant pressure of 300 mm Hg,
recording the average volumes over one minute intervals. The results and
injected infusion time for a 20 ml/kg bolus
in a 5 kg baby are shown in table 1.
Administration of intravenous fluid is an essential component of infant resuscitation.
Fluid boluses have to be infused under pres-
sure through an intravenous cannula placed in a peripheral vein. Successful cannulation
can be a technical challenge in collapsed
infants. Small veins are prone to damage
when fluids are rapidly purged through
them. Central venous access is not usually
established in infants in the immediate
resuscitation period and larger intravenous

**Figure 1** Treatment, bone age, and height of the
patient, plotted on a cross sectional growth
chart for girls (0–19 y). Height, bone age, and
growth velocity of the patient are shown. F,
father’s height; M, mother’s height.
cannulae (22 and 20 gauge) can be difficult to site in small infants presenting with circulatory failure.

Our simple experiment has shown that fluids can be infused through an intraosseous cannula at a significantly higher rate to that of the intravenous devices. The resistance to flow in situ has not been calculated, but one might reasonably expect the capacitance of the marrow cavity to be greater than that of an infant’s peripheral vein. These factors, in addition to the ease and success of placement of intraosseous over intravenous cannulae, lead us to advocate that greater emphasis is placed on the value of intraosseous cannulation during the early phase of resuscitation in infants.

This is an important issue that should be addressed both locally and nationally, as well as through advanced life support provider courses (APLS/PALS).

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DUBLIN FROSTER
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**Table 1** Results and calculated infusion time for a bolus in a 5 kg baby

<table>
<thead>
<tr>
<th>Access device</th>
<th>Gauge</th>
<th>Flow rate (ml/min)</th>
<th>Infusion time for 100 ml bolus (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow venflon*</td>
<td>24</td>
<td>35.6</td>
<td>2.81</td>
</tr>
<tr>
<td>Blue venflon*</td>
<td>22</td>
<td>60.6</td>
<td>1.65</td>
</tr>
<tr>
<td>Pink venflon*</td>
<td>20</td>
<td>126.8</td>
<td>0.79</td>
</tr>
<tr>
<td>Green venflon*</td>
<td>18</td>
<td>161.2</td>
<td>0.62</td>
</tr>
<tr>
<td>Intraosseous needle</td>
<td>18</td>
<td>248</td>
<td>0.40</td>
</tr>
</tbody>
</table>

* BOC Ohmeda AB, SE-25106 Helsingborg, Sweden.

**Family 3**—This family are Irish travellers and they have had three affected children. The first died with a severe movement disorder and the third, although he was known to be at risk, had an episode of decompensation at 6 weeks. He developed a severe movement disorder and died suddenly and unexpectedly at the age of 13 months. The second child has had some problems and attends a normal school.

None of these children were receiving any specific dietary treatment or medication. While we would agree that early diagnosis is essential, the diet is a significant imposition and all that may be needed is intensive treatment during intercurrent infections.

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JANE COLLINS
Metabolic Unit, Great Ormond Street Hospital, London, UK
J V LEONARD
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**Gastrointestinal symptoms in asthmatic patients**

EDITOR,—Caffarelli et al comment on several immunological mechanisms by which gastrointestinal symptoms could occur in asthma.1 They do not comment on whether they excluded cystic fibrosis (CF). This is relevant as there are an increasing number of mild phenotypes of CF presenting as asthma.2 CF could be a unifying diagnosis in the “asthmatic” with gastrointestinal symptoms.

The important clinical message is to consider a diagnosis of CF in difficult cases of asthma.

JOHN FURNESS
Department of Paediatrics, Sunderland Royal Hospital, Keay Road, Sunderland SR4 7TF, UK


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to increasing weight for height is bad and is due to improved overall nutrition.

No dataset can provide all the answers. By collating their long work and summarising all their analyses in this well structured and admirably slim volume, the authors make it possible for the idle and sceptical like myself to argue with their conclusions. The range of the work is vast: from heart disease risk factors and asthma prevalence, to the prevalence of enuresis and food intolerance. It may come across as surprising that the last has a strong inverse relation with level of education, but the adverse impact of food exclusion on height certainly surprised me. No doubt future generations will dip into this rich dataset and pick out many more plums to inform both research and practice. We can be grateful to Rona and Chinn for making it possible.

CHARLOTTE WRIGHT
Honorary Consultant in Community Child Health


Good, I thought, as these books dropped through the letterbox. The day before I’d been party to a family receiving an antenatal diagnosis of gastrochisis, and the father had commented on “looking it up on the Internet”. I wanted to learn more about the condition myself, and reckoned I’d follow the man’s example.

Using the Internet in Healthcare sounded an ideal title; disappointingly it wasn’t. It’s a book about the basics of the Internet, which isn’t bad, but is presented in better books (for example, Internet for dummies).

It’s “medical” legitimacy comes from a good summary of NHSnet and a crumb of information about healthcare searches on the Web. (Emarrassingly, it was MedLine: a guide to effective searching that contained the nicest www resources.)

MedLine: a guide to effective searching was also a let down. It’s beautifully written, starts with a lovely summary of the history of MedLine, but annoys with drawn out explanations of Boolean logic and historical access systems. In explaining PubMed, it doesn’t even mention the excellent “Clinical queries” search page (www.ncbi.nlm.nih.gov/PubMed/clinical.html) on the work of Brian Haynes and colleagues.

For clinicians, there are better summaries of framing questions and effective database searching in Sackett’s book.1 For researchers, there are better databases for citation searching than MedLine.

My own searches found a wonderful paediatric patient information site (http://www.birthdefects.org/MAIN.HTM), a site telling the story of a young lad with gastrochisis (http://www.geocities.com/Heartland/Flats/1558/), and an excellent study of outcome (using the PubMed/Haynes filters). I wonder how far the father of our latest premature patient fared...

BOB PHILLIPS
Paediatric Senior House Officer


Evidence based care is upon us, whether we like it or not. There is a multitude of books on the subject, so how is this one different? This is the first in the “Harnessing health information series”, and summarises how evidence based care has evolved into mainstream NHS policy. It does appear to achieve what the series supports to do, as it harnesses health information on the subject. The reader is gently guided around the different organisations set up to implement evidence based care, and is also given a description of evidence based care, with an overview of the types of research, including qualitative research, and their advantages and disadvantages. The book does not set out to duplicate the many “How to...” books, but, rather, points the reader in the right direction. There is a useful chapter on information sources on the Internet, and a comprehensive chapter on guidelines, describing most of the arguments for and against. Again, the reader is continually pointed in the direction of other useful information, without it being duplicated in this book. Patient information is covered in another chapter, and this is interesting and thought provoking reading. Audit, and where it fits into the system, is also included. Finally, clinical quality and clinical governance are brought into the picture, and it all makes sense.

Ruth Roberts is a nurse, and she emphasises the importance of multidisciplinary working. This is an easy book to digest, making common sense of what sometimes seems a complex system. It gives a “warts and all” description of evidence based care. The reader is not put off, but, rather, is left with the feeling, “I can do this.”

This will be a useful resource for managers, nurses, doctors, and clinical quality coordinators. It will be useful for senior staff with a good understanding of the health service and its current requirements, as well as being a good starting point for more junior staff who are trying to make sense of white paper recommendations, and the national organisations set up to implement those recommendations. It can be read in a couple of hours, and will no doubt become pre-interview reading for would be consultants and specialist registrars.

MAUD MEATES
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After coming to this country some years ago, I decided to take up paediatrics. I remember asking a senior colleague for advice regarding any textbook that might introduce me to the subject. She gave me a choice, but recommended that Essential paediatrics, then in its third edition, would make easy reading. I must say I found this sound advice. Of course, as a postgraduate, one had to progress rapidly on to other textbooks considered the bibles of paediatrics. Hence, when I was asked to review the fourth edition, I was overwhelmed as it brought back memories of my first few months in paediatrics.

As the editors have noted in their preface, this book is meant for medical students. I find that this has been maintained with regard to the manner in which different subjects have been handled with easy to understand language and diagrams. I continue to find the first chapter, “The ill child”, the most impressive and compelling to read, and would not hesitate to recommend this to postgraduate doctors intending to take up a first paediatric post. A similar chapter that needs special mention is that on emotions and behaviour, which, in a brief but concise manner, describes children that we meet daily. It teaches us the importance of careful history taking, including social and family histories.

The book has been updated in many areas, especially in terms of management, in keeping with an evidence based approach. The addition of the British Thoracic Society guidelines on the management of chronic asthma is commendable. However, I cannot understand why the importance of the peak flow meter has been downplayed, unlike the previous edition which also featured a graph of normal PEFR values related to height.

On the whole, Essential paediatrics can be described as user friendly, with numerous relevant line drawings and important information in the margin and in highlighted boxes. Interesting and useful x rays have also been included in this edition.

Yet why does one get the feeling that this may not be the first choice textbook for many medical students? One reason is the limited number of colour photographs compared with some other books on the market. Another reason, I would suggest, is the lack of adequate definitions of some of the common disorders—for example, coeliac disease and ulcerative colitis.

Despite some drawbacks, I find that Essential paediatrics is invaluable and have no qualms about recommending it to medical students as essential reading.

MINI MARGARET NELSON
Staff Paediatrician


Their children’s eating disorders pose serious problems for parents. They may seek professional help, but services in the United Kingdom are fragmented and under developed; therefore, any book that is designed specifically for parents remains a rare commodity.

My clinical experience is that parents appear bemused and shocked by the realisation that their daughter or son has an eating problem. They are often confused and may be angry or in denial. Parents may turn to the popular press, in which articles are sometimes sensible, sometimes sensationalist, worrying, or misleading. High profile cases, such as those of Princess Diana or Lena Zavaroni tend to dominate...

The authors have obviously recognised the lack of sensible self help and advice for parents of younger children and adolescents. This book, therefore, is timely and fills an important gap. A lot of the information is...
knowledge of paediatrics, and others appear to be aimed at the experienced paediatrician. In spite of this, there is a reasonable and logical flow to the text, and many extremely useful tables and diagrams. Key learning points and common errors are highlighted in most chapters, and there is a list of useful tips based on the considerable collective experience of the authors. This sort of approach is as close to bedside teaching that you can get in a textbook, and will be appreciated by trainees in particular.

Areas that stand out include the management of fluid and nutritional problems, toxicological and metabolic emergencies, and the diagnostic investigation of children with cardiac and respiratory problems. It is always difficult to do justice to non-clinical topics like the ethical and psychosocial aspects of critical care, but, at least by including them, the emphasis on the whole patient remains intact. Due attention is given to non-accidental injury and the challenges of transporting patients, the latter reflecting modern, increasingly centralised paediatric intensive care.

In a subspecialty defined by rapid intervention and practical procedures, it is especially difficult to strike the appropriate balance between background detail and clinical practice. On the whole, this book accomplishes this very well. It is not a comprehensive reference text for tertiary care paediatric intensivists, but covers first line treatment to optimise the transition from emergency patient to PICU patient. Until recently, this was mainly undertaken by specialist registrars and consultant anaesthetists, but, in the United Kingdom at least, the next generation of consultant paediatricians will increasingly be called upon to manage critically ill children in those crucial first hours. That group, however reluctantly, will particularly benefit from this useful text.

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In his chapter in this book entitled “Neuronal migration disorder and epilepsy in infancy”, Vigevano emphasises that brain malformations represent a causal factor in 3–4% of all epilepsies, although this percentage increases to 18–20% in drug resistant epilepsies. With every new generation of MRI scanner, more and more patients with epilepsy are recognised to have a cortical developmental abnormality, and the aetiological significance of these to the development of epilepsy has opened up exciting new fields in the understanding of the pathophysiology of epilepsy and its treatment. This book is a compilation of papers presented at a meeting on epileptogenic cortical developmental abnormalities, organised by the editors. As with books produced in this way there are strengths and weaknesses, with a bias towards specific topics of interest.

The book starts with a short introduction by Frederick Andermann, followed by several chapters on cortical development and animal models. These early chapters are not easy reading but persistence is rewarded by information of direct clinical relevance from the dry basic scientific details—for example, I learnt that work with animal models has shown that pathological changes continue for years after the initial insult, explaining the delay in the development of clinical epilepsy. Furthermore, the progressive maturation of the neurotransmitter pathways could explain why neonatal encephalopathies are often catastrophic, and why children can grow out of their epileptic tendency, even with lesional epilepsy.

The later chapters on electroclinical imaging, neuropsychological studies, genetics, and surgery are more relevant for the clinician. In this section, several of the authors emphasise the error of using the term “neuronal migration disorders” for all dysplasias, when the disturbance can be of neuronal migration or organisation and not always an arrest of neuronal migration. Of particular interest to me were the chapters on neuroradiology of malformations, neuronal migration disorders and epilepsy in infancy, schizophrenia, and genetic and neuroimaging, especially the genetic implications of recognising these various malformations. I also enjoyed Guerrini’s excellent chapter on the development of polymicrogyria. As in his other publications, he points out that polymicrogyria is the only cortical developmental abnormality which can produce ESES with eventual spontaneous remission, and when this pathology is identified on neuroimaging, surgery should be avoided. This leads us to the two chapters on the problems of resective surgery in focal developmental abnormalities and epilepsy, the first by the Montreal group and the second outlining the Italian/French experience. Both emphasise the specific difficulties of deciding the demarcation of surgical resection in these patients. I was particularly interested in the approach of Munari et al to a two step surgery, reoperating with more invasive electrocorticography if the seizures do not stop with lesionectomy alone. While acknowledging that cortical dysplasias can be intrinsically epileptogenic, Munari et al state that, in practice, the epileptogenic zone is often wider than the MRI limits of the lesion, suggesting either that the adjacent cortex is also epileptogenic or that microscopic pathology extends further than that seen on MRI images.

The book is a useful addition to the literature on cortical dysplasias. It does not aim to be a comprehensive review of the topic and the reader would need considerable prior knowledge of the subject to find the book useful.

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Health care needs for travellers

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