LETTERS TO THE EDITOR

Rapid responses
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The editors will decide, as before, whether to also publish it in a future paper issue.

Cystic fibrosis related low bone density

We were interested to read the study by Laursen et al which highlights the important problem of decreased bone mass in the cystic fibrosis population.1 The authors found that reduced bone size was primarily responsible for the decreased bone mass observed in patients aged 19 years old. These results are at variance with the findings of Gibbens and colleagues, who, using quantitative computed tomography, showed that the volumetric (three dimensional) lumbar spine bone density of children with cystic fibrosis was 10% lower (p<0.001) than in local controls.

Although these contrasting results may partially reflect true differences in bone mass between the study populations, they may also be due to regional differences in bone mass. In addition, quantitative computed tomography measurements in the spine are confined to cancellous bone whereas total body dual energy x ray absorptiometry measurements, as used by Laursen et al,1 predominantly reflect cortical bone. Both measurements are therefore useful, but contribute differently to our knowledge of the skeleton. Another more recent study supports the fact that the reduced areal (two dimensional) bone mass density documented in young patients with cystic fibrosis is due to a combination of decreased volumetric bone mass density and reduced bone size, rather than reduced bone mass density alone.1 We would therefore suggest that it is important to monitor the skeletal health of patients with cystic fibrosis (starting in childhood), ideally by performing annual bone densitometry. As fractures involving trabecular sites such as the ribs and spine are more prevalent in adults with cystic fibrosis than in the general population,1 regional rather than total body bone mass density assessments should be performed to more accurately assess fracture risk.


Non-familial short stature

EDITOR,—Cole’s proposed new chart1 would indeed detect children with non-familial short stature. Whether it would detect “hidden” pathology is less certain—data from the Wessex Growth Study suggests not. Routine investigation of all children below Tanner’s 3rd centile identified eight cases of conditional short stature.2 Three of these, already or on average near or above the current 0.4th centile, would clearly have lain above it on a conditional chart (figure I), and might easily have been dismissed as normal. Parental heights may well inform the specialist, but their usefulness in a screening programme, without a full family history, is debatable.

Conditional standards demand that all heights are measured, not estimated, and should exclude those of abnormal stature.2 Such conditions rarely hold. Few fathers, as we found, attend school medicals. In any case, by school entry, one in four Wessex children lived in single parent or reconstituted families.

Furthermore, almost half our short children, including those with pathology, had at least one parent below the 2nd centile. Short children, often assumed to be genetically short, may instead have inherited pathology. All very short children, regardless of familial height, deserve careful investigation.

Most children below the parent adjusted 0.4th centile would also fall below the unconditional 0.4th centile. As Cole admits, only when parental heights are near or above average, are additional children likely to be referred. Our data show that children who are very short, even those with clear pathology, rarely have tall or even average parents. Indeed, mean parental height of all children with pathology was as low as those without (10th centile to 7th centile).

In our study, some 10% of those short children with heights above the 0.4th centile had organic disease. As long as the fear of missed pathology remains, why not simply raise the screening threshold to a higher centile, perhaps the 2nd, and not complicate the process with a second chart?

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Professor Cole comments:

Mulligan and Voss are concerned that the conditional chart does not identify hidden pathology, but they misunderstand the chart’s purpose. It is designed for short children of tall families, not short children of short families—this group is already catered for with the unconditional chart. All the Wessex Growth Study cases of hidden pathology had shorter parents than average, so the conditional chart is not intended for them. Short children from tall families are relatively uncommon, so the cost of the extra screen is modest.

Despite what Mulligan and Voss say, familial heights do not have to be measured—it is obviously desirable but not essential. Precision of measurement is much more important for the child than for the other family member(s), due to the shape of the critical region on the chart. And the father is not essential for the assessment—the chart uses whatever family size information is available.


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**Figure 1** Height standard deviation score (SDS) of children with “silent” pathology plotted against mid parental height SDS. Three children had a height on or above both the unconditional and conditional 0.4th centile.

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**Figure 1** Height standard deviation score (SDS) of children with “silent” pathology plotted against mid parental height SDS. Three children had a height on or above both the unconditional and conditional 0.4th centile.
What Mulligan and Voss seem to be concerned about is the use of the 0.4th rather than the 2nd unconditional centile. It certainly increases the number of cases of pathology missed, but it also reduces the false positive rate by five sixths. Either way it has nothing whatever to do with familial height origin.

There are important points to mention that are missing in this paper. Why is there a need to lower the body temperature with tepid sponging even further than can be achieved with paracetamol? When we “treat” fever vigorously by combining an antipyretic drug with physical methods, we are giving the impression to parents, students, junior doctors, and others, that fever is harmful and the appropriate treatment of the child is paracetamol alone in most cases. I would go as far as saying that tepid sponging offers no advantage in the vast majority of cases. We no longer use fans and sponging, but remove some clothing (keeping a vest or a light T-shirt) during the phase of defervescence and sweating. We have not experienced any disadvantages with this current practice.

Several clinical studies have shown the beneficial effects of fever, even high fever over 40°C, and the harmful effects of the antipyretic drugs. We prescribe antipyretics because of prevailing concepts among physicians, parental expectation, and because children may show improvement in their level of activity and alertness.

Clinical methods have an important indication in cases of hyperthermia, such as heat stroke, where antipyretics are ineffective. Hyperthermia can also complicate febrile illness (vigorous muscular contractions in a child with febrile convulsion) and physical treatment may be of benefit. Several issues remain unresolved. Which diseases are likely to benefit from the presence of fever, so that minimal interference is indicated? What degree of fever is harmful and thus ought to be lowered? Finally, does antipyresis have any effect on the clinical course of infectious diseases?

Physical treatment of fever

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Guidelines for the ethical conduct of medical research involving children

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The role of lumbar puncture in meningococcal disease

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Letters
A short stay observation unit improves care in the paediatric emergency care setting

EDITOR,—The number of admissions to hospital emergency departments is increasing, by up to five per cent a year. Most of these children are under 5 years of age, and they may come straight to hospital without any preceding medical examination. Although a short stay observation unit (SSOU) has been proved essential for a good emergency service, few publications have looked at its influence on the admission rate in paediatrics. We analysed the activity of a SSOU opened in 1992 in the paediatric emergency department (PED) of the Children’s Hospital of Bordeaux. We also looked at the number of total admissions to the PED and the number of children admitted to paediatric wards between 1987 and 1996.

Among 2321 patients admitted to the SSOU in 1996, we analysed 644 medical patients (table 1): 55% of children were under 3 years old, 70% living in the town or surroundings, and only 36% referred by a general practitioner. Twenty per cent were admitted for diagnosis (group A), 50% for treatment and observation of a prediagnosed acute condition before deciding on discharge (group B), while 30% were waiting for a bed on a paediatric ward (group C). Sixty eight per cent of children spent less than six hours in SSOU, and 79% of those from groups A and B were thereafter discharged. Between 1987 and 1991, the number of medical referrals to the PED gradually increased by an average of 8.25% per year (fig 1). Similarly, admissions to paediatric wards increased by 5% per year, from 2467 in 1987 to 3541 in 1991 (fig 2). Since its opening in 1992, the activity of the SSOU increased dramatically, reaching 2141 medical admissions in 1996 (fig 2), representing a mean occupancy rate of 146%. Interestingly, although the number of medical visits to the PED continued to increase during that time (fig 1), the increase in admissions to the wards was stopped, and even decreased a little from 1995 (fig 2).

Our study demonstrates the clear effectiveness of a SSOU in limiting the number of admissions to a tertiary paediatric centre.

The opening of the SSOU in our hospital's PED allowed us to control the increase in inpatient admissions even though the number of medical referrals to the PED was still going up. This meant that inpatient wards were less burdened by emergency inpatients, who generally stay a short time in hospital, but disturb work in the specialised wards. In addition, inpatients are generally assessed by medical staff twice a day only, which may result in unnecessary delays in discharge. On the contrary, continuous observation and repeated assessments of those admitted to the SSOU facilitated more rapid discharge. The shorter length of stay in this unit reduces the risk of hospital acquired infections and limits children’s and parents’ anxiety.

The SSOU in a PED can provide comprehensive, cost effective care to patients who require short term treatment or observation, especially young children. It limits inpatient admissions, improves working conditions in specialised paediatric wards, with a degree of safety that protects the PED physician and the hospital from litigation resulting from “inappropriate” discharges leading to poor outcome.

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Table 1 Characteristics of the 644 patients admitted to the SSOU

<table>
<thead>
<tr>
<th>Setting</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>305 (47%)</td>
</tr>
<tr>
<td>Male</td>
<td>339 (53%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>181 (28%)</td>
</tr>
<tr>
<td>1 to 3 years</td>
<td>173 (27%)</td>
</tr>
<tr>
<td>&gt;3 years</td>
<td>290 (45%)</td>
</tr>
<tr>
<td>Locality of residence</td>
<td></td>
</tr>
<tr>
<td>City of Bordeaux</td>
<td>135 (21%)</td>
</tr>
<tr>
<td>Suburbs</td>
<td>316 (49%)</td>
</tr>
<tr>
<td>Other</td>
<td>193 (30%)</td>
</tr>
<tr>
<td>Route of admission</td>
<td></td>
</tr>
<tr>
<td>Via family doctor</td>
<td>211 (36%)</td>
</tr>
<tr>
<td>Self-referral</td>
<td>412 (64%)</td>
</tr>
<tr>
<td>Symptoms</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>195 (30.4%)</td>
</tr>
<tr>
<td>Fever</td>
<td>148 (23%)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>108 (16.8%)</td>
</tr>
<tr>
<td>Poisoning</td>
<td>57 (8.8%)</td>
</tr>
<tr>
<td>Neurology</td>
<td>53 (8.2%)</td>
</tr>
<tr>
<td>Dermatology</td>
<td>13 (2%)</td>
</tr>
<tr>
<td>ENT</td>
<td>13 (2%)</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>57 (8.8%)</td>
</tr>
</tbody>
</table>

Figure 1 Medical referrals to the paediatric emergency department.

Figure 2 Admission to short stay observation unit and to paediatric wards.
Guidelines for the ethical conduct of medical research involving children

MUKHLIS M MADLOM

Arch Dis Child 2000 83: 369
doi: 10.1136/adc.83.4.369d

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