Use of cyclosporin A as a steroid sparing agent in cystic fibrosis

EDITOR,—In cystic fibrosis (CF) chronic respiratory infection is countered by an intense therapy. This was dose related and of whom only one required discontinuation of CyA. Two patients did not develop transient renal impairment. These patients were able to discontinue oral steroids, and repeated remissions in CF patients where CyA had been used as a steroid sparing agent. These patients were on treatment with high doses inhaled or nebulised steroids prior to the commencement of oral steroids, and repeated attempts at reducing the steroid dose were unsuccessful. All patients exhibited steroid related complications including Cushingsoid features, growth suppression, impaired glucose tolerance, hypertension, osteoporosis, and bone fractures. The dosage of CyA was adjusted to maintain whole blood trough levels between 100 and 150 ng/ml, using CyA doses ranging from 2 to 37 mg/kg/day.

In the four patients who benefited from CyA therapy the mean steroid dose decreased from 0.86 mg/kg/day in the one month prior to commencement of CyA to 0.30 mg/kg/day six months later and 0.25 mg/kg/day 12 months later. These patients were able to discontinue oral steroids within 18 months of commencement of CyA. Two patients did not show a reduction in mean steroid dosage, one of which underwent a successful heart-lung transplantation.

In the four patients who responded to CyA, lung function was maintained or improved, as were Chirsip-Norman chest x ray scores. Height velocity was also improved. Three patients did develop transient renal impairment, of whom only one required discontinuation of CyA. This was dose related and reversible but is infrequent with lower dose regimens used for anti-inflammatory therapy. Other side effects due to CyA were minimal, including mild hypertrichosis and gingival hyperplasia. There was no evidence of hypertension, hepatotoxicity, or neurotoxicity. The side effect profile of CyA is no more severe than for other immunosuppressive agents.

It is evident that CyA is a powerful but potentially toxic therapeutic agent and its use should be balanced against the risks of the disease and the long term use of steroids. These results suggest that CyA can be beneficial as a steroid sparing agent in CF patients; these data may be of help to the clinicians in comparable clinical circumstances.

We are grateful to Dr CE Daman-Willems, Dr R Dinwiddie, Prof JP Price, Dr HA Wyatt, and Dr GJ Connell for allowing us to use their patients in this report.

G K BHAL
S A MAGUIRE
M BOWLER

Survey of criteria used to diagnose allergic bronchopulmonary aspergillosis in cystic fibrosis

EDITOR,—Allergic bronchopulmonary aspergillosis (ABPA) creates a difficult diagnostic and management problem in patients with cystic fibrosis (CF). The six major diagnostic criteria for ABPA in CF were adapted from asthma guidelines. Retrospective studies report significant variability in prevalence and the numbers of criteria for diagnosis. This is important as CF databases (UK CF database, European CF and the North American CF database) report ABPA frequency either without ascertaining the criteria used, or using limited diagnostic criteria. We have assessed consensus current practice of criteria used by UK clinicians to support a diagnosis of ABPA and how cases were treated.

This retrospective, descriptive postal questionnaire survey was addressed to senior consultants in the 58 CF specialist clinics identified by the UK CF Trust. A total of 45 replies were received (78%); three were illegible/incomplete. Results are based on 42 replies (72%) from 14 adult clinics (33%), 23 paediatric (55%) clinics, and five (12%) mixed adult/paediatric clinics. Units had a median of 100 patients (interquartile range (IQR) 63 to 160).

Of six ABPA major criteria investigations (table 1), centres routinely tested (at least yearly) a median of four (mode five).

Clinicians were also asked how many of eight factors (table 1) associated with ABPA diagnosis must be present, were preferred to be present, or were not considered important. It was considered that a median of two factors (IQR 1 to 4) must be present, three preferred to be present (IQR 2 to 5), and one factor was not considered important (IQR 1 to 2.3). Forty percent of centres considered one or more further factors in addition to those provided.

Thirty eight per cent of centres would begin treatment without clinical deterioration (62% treat on deterioration). Initial treat-ment in all centres (100%) was prednisolone: in paediatric patients 1 mg/kg/21% and 2 mg/kg in 76%; in adults 30 mg/day in 50% (range 20–60 mg/day). In response to failure of steroid treatment 33% would add an antifungal agent, 17% would increase steroid dose (17% no experience against steroid failure, 12% other, 21% no reply). Oral antifungals had been used by 69% of respondents, itraconazole in all cases. Paediatric centres were much more likely to use oral antifungals (88% ± 31%, p = 0.004, Mann–Whitney U test). Nebulised antifungals were used by 21%, amphotericin in all cases.

We also asked how many patients would currently be diagnosed as having ABPA in that unit using: (a) criteria stated as “must be present” earlier in the questionnaire; and (b) if major criteria were strictly adhered to. Clinicians considered that they had a median of 5% of patients with ABPA (IQR 1 to 8), using their own criteria, falling to a median of 0% (IQR 0 to 3) when all major criteria were strictly adhered to.

This questionnaire shows considerable variability in the criteria used to diagnose ABPA in CF. Prospective reporting of cases with defined criteria will be the only way to reliably identify the true prevalence of ABPA. Database surveys may overestimate the true prevalence.

S CUNNINGHAM
S L MADGE
R DINWIDDIE
Peter Ashman
Intensive Care and Respiratory Medicine,
Great Ormond Street Hospital for Children,
Great Ormond Street, London WC1N 3JH, UK
stev.cunningham@sal21.com

Subnormal growth in children with Helicobacter pylori infection

Editor,—We read with interest the study by Choe and colleagues1 in which they investigated the effect of Helicobacter pylori infection and iron deficiency anaemia on growth, especially in pubescent children. In this study, height values were found to be below the 25th centile in 18 of 63 (28.6%) H pylori positive children. The prevalence rate of H pylori infection was 15.9% in children without iron deficiency anaemia and 31.3% in those with iron deficiency anaemia (p = 0.022). They also revealed that the mean height of subjects who had both H pylori infection and iron deficiency anaemia decreased significantly. They concluded that H pylori infection accompanied by iron deficiency anaemia,

Table 1 Replies to questionnaire (% of all units)

<table>
<thead>
<tr>
<th>Assessed yearly or more</th>
<th>Must be present</th>
<th>Prefer to be present</th>
<th>Not important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspergillus precipitins</td>
<td>83</td>
<td>42</td>
<td>49</td>
</tr>
<tr>
<td>Aspergillus specific IgE</td>
<td>52</td>
<td>54</td>
<td>31</td>
</tr>
<tr>
<td>CXR infiltrates</td>
<td>95</td>
<td>38</td>
<td>48</td>
</tr>
<tr>
<td>Blood eosinophilia (&gt;500/mm³)</td>
<td>83</td>
<td>24</td>
<td>56</td>
</tr>
<tr>
<td>Aspergillus fumigatus skin test</td>
<td>5</td>
<td>11</td>
<td>50</td>
</tr>
<tr>
<td>Total serum IgE (&gt;1000 ng/ml)</td>
<td>79</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheeze/cough</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Six major criteria investigations.
rather than H pylori infection alone, might delay pubertal growth.

We investigated the frequency of diminished growth in 30 H pylori positive children (21 girls and 9 boys) diagnosed by serology and histology. The mean age was 11.5 (2.0) years (range 8–15). We found 11 (36.7%) H pylori positive patients with height values below the 25th centile. Anaemia was determined in none of the patients. Mean haemoglobin concentration was 130 (9) g/l. H pylori infection is a chronic persistent infection, leading to diminished growth. Chronic gastric inflammation, dyspepsia, decreased nutritional intake, and malnutrition patients.

Chronic gastric inflammation, dyspepsia,

patients.

globin concentration was 130 (9) g/l. H pylori infection is a chronic persistent infection, leading to diminished growth. Chronic gastric inflammation, dyspepsia, decreased nutritional intake, and malnutrition patients.

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We investigated the frequency of diminished growth in 30 H pylori positive children (21 girls and 9 boys) diagnosed by serology and histology. The mean age was 11.5 (2.0) years (range 8–15). We found 11 (36.7%) H pylori positive patients. We did not detect anaemia in H pylori positive patients with diminished growth. We suggest that the development of short stature in H pylori positive patients may be due solely to H pylori infection itself, and is not related to iron deficiency anaemia.

HULYA DEMIR
INCI NUR SALTIK
NURTEN KOÇAR
AYSEL YUCE
HASAN ÖZEN
FIGEN GURUKAN
Hacettepe Universitesi Dokuzemek hastane, Gastroenteroloji Unitesi, 06100 Ankara, Turkey
email: ayuce@hacettepe.edu.tr

Growth monitoring

EDITOR,—Garner and colleagues recently presented a much needed review of growth monitoring.1 This is a component of primary health care on which so much finance and health workers’ time is being expended. No doubt this review will stimulate more necessary trials.

However, they did not touch on one important aspect of growth monitoring—that is, whether health workers using growth charts comprehend the weight for age graph. Piaget (1962–1980) considered the construction of line graph to be one of the more difficult subjects to teach. Graphic representation of numbers is not taught in primary schools in developing countries and colleagues with knowledge of primary education suggest that primary school teachers in these countries would not be able to teach it. Experience with post-graduate doctors in the 1970s suggested that a proportion could not complete a weight chart and even fewer would have problems in interpreting it. A similar problem has arisen with midwives in the use and interpretation of the partograph to plot the progress of labour.

Fortunately, an alternative method of weighing overcome this difficulty. This method involves weighing in or near the home, not in the clinic, with a Direct Recording Scale. With this, the parent sees a large spring stretching up their child’s chart, located in the home, as they release the child’s weight into the weighing trousers below the scale. With a ball pen, they then create the next point on the child’s growth curve through a hole in the pointer at the top of the spring. In this way, even uneducated parents can create their child’s growth curve. This, in time, leads them and their relative to understand the weight for age curve.1 In one study among the pastoral Maasai in Kenya, action was taken by the parents to give an additional drink of milk to children whose weight for age was faltering (Meegan M. Personal communication, 1999).

D MORLEY
51 Eastmoor Park, Harpenden, AL5 IBN, UK
Dmorley@morleydc.demon.co.uk

Detecting outbreaks of E coli O157 infection in nurseries

EDITOR,—In their report of a serious outbreak of E coli O157 in a nursery in North Wales, Al-Jader and colleagues recommend that more than one child with more than one bowel motion should trigger action including “informing and seeking the advice of public health agencies”.1 Using data on healthy children aged 2–5 years in the paper we have calculated the additional work that would be generated for the Public Health Department in the district where the outbreak occurred if this policy was implemented.

19 of well children on the ground floor of the nursery, six had more than one bowel motion on at least one of the half day sessions attended during the surveillance period.2 Well children attending nursery for six days during the period, giving an approximate total number of sessions attended of 228 (19×6=2). The probability of a well child having more than one bowel motion during any half day session was therefore about 0.026 (6/228). There are 385 day nurseries and playgroups in North Wales, with an average of 23 children per nursery.3 In an average nursery the probability that two or more well children would have more than one bowel motion in a session on any one day is 0.12, equivalent to a false alarm every eight days.

Therefore, if the suggested policy was implemented, and incidents were reported to the Public Health Department, this would result in approximately 46 inappropriate calls per day (0.12×385)—that is, 230 per week. Even if the normal background rate was ten times lower than that seen among well children during this outbreak, this would still result in just over three calls a week to the department reporting false alarms. The proposed “early warning system” is therefore almost unworkable, and the claim that it could have prevented 10–12 of the 31 cases in the outbreak needs to be reviewed.

R J ROBERTS
Consultant Communicable Disease Control, Department of Public Health, North Wales Health Authority, Hendy Road, Mold, Flintshire CH7 1PZ, UK
Dr.richard.roberts@wales-ba.trades.nhs.uk

Meningococcal disease due to W135: fresh public health concerns

EDITOR,—The paediatric intensive care unit at St Mary’s Hospital in London admits more than 100 cases of meningococcal disease each year from over 50 different hospitals in the south east of England. Since 1992, the unit has treated over 650 patients with the disease, but had not treated a single case of serogroup W135 meningococcal infection until April 2000. We would like to report four children treated at our unit for meningococcal infection due to serogroup W135, type 2A, subtype P1.2, P1.5, within a one month period from April 2000. They had been vaccinated recently with meningococcal serogroup C conjugated vaccine, and had all been
in contact with travellers returning from Mecca. The clinical features of these cases are outlined in table 1.

This figure represents four out of 38 cases (with five fatalities) of serogroup W135 Neisseria meningitidis infection in England and Wales within the six week period from March to May 2000 (PHLS Meningococcal Reference Unit, personal communication), with hundreds of cases of the identical subtype reported in Saudi Arabia. It is thought that this large outbreak of an unusual strainoriginated in Saudi Arabia, with the pilgrimage of a record 1.3 million people to the Haj between 15–18 March 2000. A similar outbreak occurred in 1987, due to serogroup A, subgroup III. This also followed the yearly pilgrimage to Mecca, and spread throughout Europe, USA, and Africa over the next two years. Requirements for pilgrims entering Saudi Arabia now include documented vaccination with meningococcal A and C polysaccharide preparation. This public health measure has been effective in irradiating serogroup A disease in these travellers. A quadrivalent vaccine is available for serogroup W135 as well as serogroups A, C, and Y. This vaccine, however, is not licensed in the UK, and is only available on a named patient basis. This raises public health issues, including whether people returning from Mecca to the UK should be screened or not.

Even with the anticipated beneficial effects of the meningococcal C vaccination programme in England and Wales, it is important to remember that other serogroups of meningococci will continue to cause significant disease in the UK.

Until 1950, England was predominantly affected by epidemics of serogroup A meningococcal disease. The switch to serogroup B and C disease occurred after the second world war, and serogroup A disease is now rarely seen in the UK. Neisseria meningitidis has the potential to alter its capsular polysaccharide antigen through recombinational exchanges at the capsular locus. In his commentary in the Lancet in 1999, Martin Maiden expressed concern that new hyper-virulent strains of serogroups including B, W135, and Y may emerge as serogroup C disease is eliminated. This recent outbreak of serogroup W135 infection does not seem to represent such selection pressure. However, it highlights the need for continued clinical, laboratory, and epidemiological vigilance for meningococcal infection, particularly now that there may be a theoretical risk of other serogroups becoming more prevalent as meningococcal serogroup C disease is controlled.

Table 1 Clinical presentation, severity and outcome

<table>
<thead>
<tr>
<th>Case sex</th>
<th>Contact with travellers</th>
<th>Presentation</th>
<th>Resuscitation fluid*</th>
<th>Maximum intraves (days)</th>
<th>Mechanical ventilation (days)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 10m/F</td>
<td>Grandmother</td>
<td>Petechiae, septicaemia</td>
<td>80 ml/kg fluid</td>
<td>2</td>
<td>Discharged</td>
<td></td>
</tr>
<tr>
<td>2 27m/M</td>
<td>Father</td>
<td>Purpura fulminans, septicaemia</td>
<td>350 ml/kg fluid fluid adrenaline 2.2 mcg/kg/min</td>
<td>11</td>
<td>Peripheral gangrene</td>
<td></td>
</tr>
<tr>
<td>3 4m/F</td>
<td>6 family members</td>
<td>Purpura, septicaemia, no rash</td>
<td>90 ml/kg fluid dopamine 10 µg/kg/min</td>
<td>0</td>
<td>Neurological sequelae</td>
<td></td>
</tr>
<tr>
<td>4 19m/F</td>
<td>2 Aunts</td>
<td></td>
<td></td>
<td>2</td>
<td>Discharged</td>
<td></td>
</tr>
</tbody>
</table>

*Total resuscitation fluid required in first 24 hours

The following is a summary of the management of meningococcal disease as outlined in table 1.

**Prevention and treatment of cow's milk allergy**

Editor,—Divergences in existing guidelines on the prevention and treatment of cow's milk allergy (CMA) in infants[1] seemed settled when a joint statement by the committees of ESPACI/ESPAGAN appeared in *Arch Dis Child* 1999;80:290–6. However, this is not the case. Several recent studies have suggested that almost a third of neonatal cases of galactose ischaemic encephalopathy, and recommended that, because of the high proportion of atypical cases, all children with early onset (younger than 3 years old) intractable seizures or status should receive a trial of pyridoxine dependency present with apparent birth asphyxia and/or submersion, or ischaemic encephalopathy, and recommended that, because of the high proportion of atypical cases, all children with early onset seizures or status should receive a trial of pyridoxine whatever the suspected cause. Following this recommendation can be of remarkable benefit.

We report a case of a caucasian boy, born at term who presented at delivery in a state of unexpected collapse requiring intubation and resuscitation. He developed tonic seizures within hours of birth and was treated with phenobarbitone, phenytoin, and clonazepam. At 48 hours, an EEG showed a burst

P BOLT J BRITTO S NADEL M LEVIN Department of Paediatrics, Imperial College School of Medicine at St Mary’s Hospital, South Wharf Rd, London W2 1NY, UK

E-mail: j.britto@ic.ac.uk


suppression pattern. There was biochemical evidence of multi-organ damage. He was extubated on day 5 and discharged on day 16 on phenobarbionate. He continued to have frequent myoclonic seizures. At 6 months, phenobarbionate was replaced by sodium valproate with some initial benefit. By 7 months, he was having focal motor seizures affecting his right arm up to 40 times a day and additional atypical absences and tonic seizures. He also showed signs of an emerging spastic quadraparesis. EEG showed right sided spike and wave discharge with a frontal emphasis. At 8 months a trial of oral pyridoxine (30 mg/kg/day) was given. No seizures have been observed since pyridoxine was started. He is now 16 months old. He is maintained on pyridoxine 15 mg/kg/day; valproate has been discontinued. The EEG no longer shows spike and wave activity. The signs of spastic quadraparesis remain.

We have reviewed the notes of children attending The David Lewis Centre, a residential school for children with severe epilepsy. Children at The David Lewis Centre are referred from all over the UK and their early epilepsy management has been undertaken at many different centres. 31 children with intractable cryptogenic epilepsies, which started before they were 3 years old, were identified (dates of birth: 1979–1992). Only one of these children was recorded as having received a trial of pyridoxine early in the evolution of their epilepsies. The true prevalence of pyridoxine responsive epilepsy is difficult to assess if the recommendations of Baxter are seldom applied. Giving pyridoxine can be diagnostic and therapeutic—not giving a trial of pyridoxine can be common and can have a treatable cause of difficult epilepsy unrecognised and inadequately treated.

D HINDLEY Consultant Paediatrician, Fairfield General Hospital, Rochdale Old Road, Bury BL9 7TD, UK
M HUTTON Associate Specialist, The David Lewis Centre, Alderley Edge, Cheshire, UK


Are sleep studies worth doing?

Editor,—If sleep studies are worth doing, they are worth doing well. The study of sleep is usually ignored in the United Kingdom? What are the results of sleep studies worth doing? 1

The studies of sleep are worth doing well. The study of sleep is usually ignored in the United Kingdom. The results of sleep studies are worth doing well. The study of sleep is usually ignored in the United Kingdom. What are the results of sleep studies worth doing?

The data presented do not justify pessimistic conclusions.

Editor,—In a recent article, Cavadini and colleagues told us that during the past thirty years the youth in the US have shown a decrease in total milk consumption, as well as the percentage of energy from fat and, particularly, saturated fats. What are the conclusions of the article? That “these trends... may compromise the health of future US populations”.

In the discussion section the authors expressed concern about low iron and fibre intakes, despite the fact that both have risen steadily in the past 30 years. Concern is also expressed about falling calcium intake, due to a decrease in consumption of dairy products. US milk intake has always been exceptionally high and, being rich in saturated fat, a reduction is probably desirable. However, the current lower intake still supplies levels of calcium much higher than those for children in other developed countries.

There seems little doubt that US children are growing fatter, but I am at a loss to see in what way their dietary intake explains this. Presumably the reduction in energy intake is offset by an even greater reduction in activity, but the effect is that, in composition terms, the diet of today’s adolescents is dangerously unbalanced, supplying more energy than required for current levels of activity, and even suggesting that some things might be improving instead of getting worse.

The old fashioned discipline of mother used to scold her children in the next room “whatever you’re doing: stop it!” This seems to us to be our attitude towards young people as a group. It is sad to see a scientific article falling back onto the accepted paradigm that the youth of today are decadent and unhealthy. Could the authors not have had the imagination to explore the meaning of these results and even suggest that some things might be improving instead of getting worse?

C M WRIGHT Community Child Health Unit, Department of Paediatrics, 13 Walker Terrace, Gateshead NE8 3EB, UK


Spacers and holding chambers: Not the last word, we hope

Editor,—Zai and colleagues compared homemade spacers with two commercially available valved holding chambers (VHCs) for the treatment of children with acute asthma. 1,2 As the manufacturer of one of the VHCs that was evaluated, I acknowledge that the practice of using empty drink bottles is common in some countries (either by necessity or choice), but we are highly concerned about the support to the hypothesis, given by implication in this paper, that coffee cup or drink bottle spacers are as effective as properly designed add on devices.

In this paper, the production technique did not simulate the release of medication from a pressurised metered dose inhaler (pMDI). Instead, the technique created a radio labelled aerosol by pneumatic nebulisation into a bag (which would have acted as a particle pre-selector). This set up would not have reproduced accurately the ballistic component (polydisperse particles) that is inevitably released at actuation of a pMDI. The paper has already been shown that these particles are more effectively separated by a VHC than a spacer (with no valve). Had a pMDI containing the radio-labelled aerosol been used (as is the normal practice in gamma scintigraphic studies evaluating pMDI systems), we believe that the dynamic aerosol behaviour (inertial impaction of the ballistic component, turbulent deposition, etc) following actuation into the chamber would have been quite different to that observed by having patients drawing in the already formed aerosol from the nebuliser bag. Simply put, the protocol more closely simulated a continuous jet nebuliser releasing a liquid phase aerosol into a bag that was then connected to a chamber/spacer device and may therefore have evidenced to what occurs inside a VHC used with a pMDI.

A well designed holding chamber (with a valve) will retain a significant portion of the coarse component of the emitted dose (parti-
in feeding problems, which may highlight the several chapters of this book there is a difficulties. In understanding of feeding division. Given the wide prevalence of feeding problems, it is important for all health professionals working with children to gain an understanding of feeding difficulties. In several chapters of this book there is a refreshing focus on the role of organic factors in feeding problems, which may highlight the wide range of subtle organic features that can contribute to and exacerbate feeding difficulties in children. The impact of other factors on feeding is also covered—for example, the effect of temperament, appetite, growth, developmental stage, prior experience with foods, and cognitive development, all of which are critical in understanding each child’s feeding difficulty and creating appropriate intervention strategies.

The various etiologies of feeding difficulties from physiological (oral motor, regulatory, neurological), psychological (behavioural, cognitive behavioural, and psychoanalytical) and cultural perspectives are covered. These are discussed from a multidisciplinary teamwork and the development of both hospital and community feeding services. The chapter covering the psychoanalytical perspective sits somewhat oddly within the context of the book. Less helpful advice and practical intervention techniques stem from this chapter than the others, but perhaps those with an interest in psychoanalysis will find it an appealing diversion.

It is vital that health professionals in this field develop an understanding of the impact of cultural factors, from the effect of cultural feeding practices on feeding difficulties, to the perception and importance of food and feeding within cultures. This is critical in understanding the factors that contribute to the development and maintenance of feeding problems in children, and is also essential to facilitate culturally sensitive intervention strategies. The perspectives of Indian culture are discussed and whilst one text alone cannot cover the breadth of multicultural issues that are relevant to the UK population, there is useful retrospective on issues which are specifically related to cultural practices and those which are related to social disadvantage and poverty in general.

Whilst some chapters focus on clinical practice and opinion that may not appeal to an academic audience, practical advice, such as special issues in tube feeding, neurological impairment, and chronic illness, combined with generally sound theoretical discussion, makes this text a useful resource for health professionals involved in the assessment or treatment of feeding difficulties.


Share prices of dot.com companies have plummeted because, as we are told, there are too many players in the market place for them all to be viable. The dot.com bubble has burst. This may also be true of paediatric textbooks.

Such thoughts might trouble the authors and publisher of the fourth edition of the ABC of One to Seven, were it not for the pictures it contains. Is there really demand for another general paperback text covering well trodden ground, with predictable text and liberal use of blue boxes to convey the impression that there is a lot more colour than is really the case? Perhaps not, but for those pictures. This book isn’t cheap, and maybe that’s because of the pictures. In short, this book is worth the investment for the pictures alone.

Medical students like to console themselves with thick books because many of us still hold fast to the well known belief that you can learn a lot about a subject by buying a “good book”, even without opening it. Perhaps the same is true of GP’s; fat books with hardback covers are much more impressive shelf-fillers than paperbacks with pictures.

But what about when the time comes to learn paediatrics? We need something on which to hang the facts of any textbook, and we all know the daunting effect of long paragraphs of plain text on page after page. This is where pictures and diagrams come into their own, and the ABC of One to Seven has them in spades. They are almost always helpful and relevant—if not adding to the explanation, then proving the useful peg on which to hang a particular fact. Captions though, are few and far between. The reader can sometimes be left confused as to the purpose of a particular illustration. Several of the pictures appear two or three times and others are decidedly outdated. Ambulances and toys appear two or three times and others are particularly the dermatological pictures, are excellent.

This is no reference bible, and the text is simple and narrative. Facts are not flung at the reader, and the practical is emphasised over the theoretical. This is a book to demystify infancy and early childhood—the fear of the unknown can quickly be replaced with enthusiasm for such a fun subject area. The Colour Atlas of Kids: this bubble definitely remains intact.

JACKIE BLISSETT

School of Psychology, University of Birmingham

BOOK REVIEWS


Given the wide prevalence of feeding problems in children and their potential impact on health, it is important for all health professionals working with children to gain an understanding of feeding difficulties. In several chapters of this book there is a refreshing focus on the role of organic factors in feeding problems, which may highlight the virtues it contains. Is there really demand for another general paperback text covering well trodden ground, with predictable text and liberal use of blue boxes to convey the impression that there is a lot more colour than is really the case? Perhaps not, but for those pictures. This book isn’t cheap, and maybe that’s because of the pictures. In short, this book is worth the investment for the pictures alone.

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NICK JENKINS

CORRECTION

In a recent letter by Russell and Gillett (Arch Dis Child 2000;85:436), the sentence: “The in house assays used for AGA and EmA were performed on 10–20 ml of serum or plasma; thus capillary samples were more than adequate.” should have read: “The in house assays used for AGA and EmA were performed on 10–20 microlitres of serum or plasma; thus capillary samples were more than adequate”. We apologise for this error.
Detecting outbreaks of *E coli* O157 infection in nurseries

R J ROBERTS and A V SWAN

*Arch Dis Child* 2001 84: 89
doi: 10.1136/adc.84.1.89d

Updated information and services can be found at:
http://adc.bmj.com/content/84/1/89.7

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