LETTERS TO THE EDITOR

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Imaging the less seriously head injured child

EDITOR,—I read with interest the recent paper by Glasgow and McGovern which suggested that bruising with a yellow hue suggests that injury occurred at least 48 hours earlier.1 Unfortunately, this statement is not referenced. However, I am aware of three papers on the age and colour of bruising.2,3 Langlois and Gresham2 studied the colour changes of bruises with time and found it was possible to conclude only that a bruise with a yellow colour was more than 18 hours old. The significance of the appearance of other colours in terms of estimating the time of occurrence was not helpful.

Stevenson and Bialas4 also found that aging of bruises was much less precise than text books imply and found that green or yellow hues suggest an injury that is at least 24–48 hours old. Finally, Schwartz and Ricci5 concluded that the available literature does not permit the estimation of a bruise’s age from colour with any precision.

I should be grateful to know if Glasgow and McGovern found any further research to assist them in aging bruises as I make a particular point of urging extreme caution on statements which specify the age of injuries based on their colouring when I teach child protection and when I write medicolegal reports.

L LIGHT
Consultant Community Paediatrician and Designated Doctor, Child Protection
Greenhill Health Centre, Church Street,
Lichfield WS13 6JL, UK

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

EDITOR,—In his recent letter, Dr Mitchell was concerned that the methodology used in our study did not simulate the release of aerosol from a metered dose inhaler (MDI).1 However, as we discussed, the method of aerosol delivery in our study differs from that of a MDI but, because the delivery system was kept constant and the particular spacer varied, a valid comparison of the efficacy of different spacers could be made.2 This delivery system has been previously developed and tested in older children.3 In these studies, aerosol lung deposition was equivalent from a conventional spacer or sealed modified bottle spacer, although a cup performed poorly and delivered significantly less aerosol to the lungs than did the other spacers. The validity of these findings was borne out by the results of a clinical study in which a similar Spacer to bronchodilator was obtained when children with acute asthma were given a β2 agonist via an MDI-bottle or conventional spacer but a poor response occurred in those using a cup.4

We agree with Dr Mitchell that the presence of an inhalation valve may affect pulmonary deposition of aerosol. However, valveless spacers may also function efficiently as spacers. When compared to an MDI alone, increased lung deposition has been reported with a valved cone spacer and a valveless tube spacer.5 These two spacers have also been found to produce similar increases in bronchodilation compared to a MDI alone.6 Moreover, oropharyngeal deposition may be reduced by up to 60% with a valveless spacer.7 Recently, valveless spacers have been reported to enhance the delivery of aerosol to the lungs in infants with chronic lung disease, when compared to the same spacer with a valve.8 The results of our clinical study suggest that a valveless bottle spacer provided effective drug delivery to the lungs resulting in similar bronchodilation compared to that obtained with a valved conventional spacer.9

The availability of a spacer device is essential in order to provide care to children with asthma. For many children, particularly those in developing countries, a low cost spacer is not available. We believe that our studies have shown that a modified 500 ml plastic bottle functions effectively as a spacer by providing equivalent or superior aerosol deposition to a conventional spacer and producing similar clinical improvement. Such a bottle spacer is the first step towards providing asthma care to many children throughout the world.

H J ZAR
Department of Paediatrics and Child Health, Red Cross Children’s Hospital, University of Cape Town, South Africa

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1 Mitchell JP. Spacers and holding chambers: not the last word, we hope. Arch Dis Child 2001;86:492.
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L LIGHT

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