Infantile colic and chiropractic spinal manipulation

Editor,—We congratulate Olafsdottir et al on their article. The sum of the evidence on spinal manipulative therapy (SMT) in the treatment of infantile colic now is that there are 3 randomised controlled trials (RCTs) on the subject.

Two RCTs demonstrated a significant positive effect of SMT;1 2 and 1 RCT was unable to demonstrate any treatment effect.3

The reasons for this discrepancy are not known, but Olafsdottir et al suggest that their finding of no effect of SMT may be due to the blinding of the infants’ mothers. Another equally likely explanation could be that we are witnessing a dose response phenomenon.

In their trial, Olafsdottir et al used a treatment protocol of a maximum of 3 sessions of SMT, whereas the other 2 RCTs, which found a positive treatment effect, used a treatment protocol relying more on the treating chiropractor’s clinical judgement. This more pragmatic approach resulted in 64% of the infants in one RCT receiving 4 or more sessions of SMT (with a maximum of 7);4 and the majority of infants in the other RCT receiving up to 6 sessions.5 We believe that this dose response problem should be addressed in future trials of SMT for infantile colic.

N GRUNNET-NILSSON
University of Southern Denmark
n.nilsson@samfund.sdu.dk

JESPER WIBERG
Private practice, Copenhagen, Denmark


Diluted treatment effects

Editor,—If my reading of this colic study is correct, it appears that both groups received standard counselling and recommendations for the care of a colicky child. My question to the authors is, are these recommendations effective in the reduction of colic, does this not raise the possibility that any treatment effect in the SMT group could have been diluted by the introduction of a second active treatment (standard recommendations) in the control group? Put another way, was the placebo intervention an inert intervention or was it a second active intervention?

G W KUKURIN
D C DACAN
Pittsburgh, PA, USA
doc@adm-comped.com

Diluted treatment effects

Editor,—If my reading of this colic study is correct, it appears that both groups received standard counselling and recommendations for the care of a colicky child. My question to the authors is, are these recommendations effective in the reduction of colic, does this not raise the possibility that any treatment effect in the SMT group could have been diluted by the introduction of a second active treatment (standard recommendations) in the control group? Put another way, was the placebo intervention an inert intervention or was it a second active intervention?

G W KUKURIN
D C DACAN
Pittsburgh, PA, USA
doc@adm-comped.com

Alcopops are not responsible for acute paediatric attendances with alcohol intoxication

Editor,—We were interested to read Dr Robson’s leading article regarding alcohol misuse and the reference to acute alcohol admissions to Alder Hey in Liverpool, UK.1 2 We too are concerned by the increasing number of these problems that we see in hospital paediatric practice.

We carried out a retrospective case note review of all the children seen in the Paediatric Emergency department in Sunderland between November 1999 and October 2000. One hundred children (57 girls and 43 boys) were reviewed for 106 attendances with acute alcohol intoxication (2 children attended twice and 2 three times). The notes of 97 attendances were available for review. Most children were aged 13 to 15 (77%), range 10–16 years. As might be expected, the majority presented during the weekend (66%) and in the evening or at night (84% between 19:00 and 01:00).

Half had been drinking with friends in a public place, although precise details were not recorded in many cases. Sixty one children (63%) were brought in by emergency ambulance and 48 (49%) were admitted. Thirty (31%) were documented to have been drinking vodka, 21 cider (22%), 12 (12%) beer or lager, 11 (11%) other alcohol (e.g. wine and 8 (8%) a combination of these. The type of alcohol was not recorded in 7 (7%) cases.

In no cases were alcopops thought to be the beverage responsible for the acute attendance, and the beverages consumed are compared with Alder Hey figures from 1996.6

A little of it.

507

401.

514–18.

314

Cl


K POTIER DE LA MORANDIERE
Department of Paediatrics, Sunderland Royal Hospital, Kayl Road, Sunderland SR4 7TD, UK
davisdeland@hotmail.com

Commentaries—read with caution!

Editor,—The commentary by Lenney correctly points out that clinicians are often slow to apply good research evidence to clinical practice.1 However, the choice of once daily intravenous gentamicin to illustrate this point is unfortunate. Extended interval aminoglycoside dosing is widely used in paediatric and neonatal practice for the treatment of serious gram negative infections, the treatment of newborn infants with sepsis, and the treatment of chronic Pseudomonas aeruginosa infection in patients with cystic fibrosis. However, the implementation of extended interval dosing has not been based on the results of appropriately designed trials in children and neonates.

The largest meta-analysis of single versus multiple daily dosing of aminoglycosides for the treatment of gram negative sepsis included only 2 paediatric studies.2 3 The use of once daily aminoglycosides in children and the newborn is still currently unlicensed. Finally, a recent systematic review of once daily versus multiple daily dosing of aminoglycosides in CF concluded that there was insufficient evidence to recommend a change in practice.4 This was because most clinical trials were of insufficient quality or were performed in adults and the results should not be extrapolated to children.

We argue that the presence of evidence that they are a problem in relation to acute intoxication presenting to Accident and Emergency. We support the statement that children will mimic adults in their use and misuse of alcohol, and consider that it is society’s changing attitude to alcohol and not the type of alcohol available that is of concern.

K TAN
Academic Division of Child Health, University of Nottingham, Nottingham, UK
Kelvin.Tan@nottingham.ac.uk

A SMYTH
Nottingham City Hospital NHS Trust, Nottingham, UK


Rapid responses

If you have a burning desire to respond to a paper published in ADC or FoEN, why not make use of our “rapid response” option?

Log on to our website (www.archdischild.com), find the paper that interests you, click on “full text” and send your response by email by clicking on “submit a response”.

Providing it isn’t libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on “read cLetters” on our homepage.

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

LETTERS TO THE EDITOR

www.archdischild.com
Other implications of disposable nappies

Editor,—Partsch, Aukamp, and Sippell propose that increased testicular temperature in early childhood might affect later spermatogenesis. They suggest that disposable nappies might contribute to this and demonstrate a significant difference between the scrotal skin temperature recorded in infants using disposable nappies and washable cotton nappies. They mention in their introductory paragraph that other environmental factors may be important in the deterioration seen in male reproductive health over recent years, but do not relate any of these factors to disposable nappies.1

There are many concerns about the use of disposable nappies in addition to increasing scrotal temperature that may impact on fertility and general health. The disposable nappy consists of a plastic outer layer, a layer of superabsorbent chemicals and inner liner. Nappies are not subject to government controls or independent testing and disposable nappy manufacturers do not need to disclose the contents.2,3

Recently, concern has been raised about the presence of Tributyl Tin (TBT) in disposable nappies. Greenpeace and Women’s Environmental Network have commissioned research which showed that there were significant levels of TBT in many brands of disposable nappy, including those on sale in the store that the family may be in contact with up to 3.6 times the WHO’s estimated tolerable daily intake. TBT is an environmental pollutant which is used in anti-fouling ship paint. It is known to disrupt the endocrine and reproductive systems. It is known to increase the skin temperature that may impact on fertility and general health. The disposable nappy consists of a plastic outer layer, a layer of superabsorbent chemicals and inner liner. Nappies are not subject to government controls or independent testing and disposable nappy manufacturers do not need to disclose the contents.3

There are many concerns about the use of disposable nappies in addition to increasing scrotal temperature that may impact on fertility and general health. The disposable nappy consists of a plastic outer layer, a layer of superabsorbent chemicals and inner liner. Nappies are not subject to government controls or independent testing and disposable nappy manufacturers do not need to disclose the contents.2,3

There are many concerns about the use of disposable nappies in addition to increasing scrotal temperature that may impact on fertility and general health. The disposable nappy consists of a plastic outer layer, a layer of superabsorbent chemicals and inner liner. Nappies are not subject to government controls or independent testing and disposable nappy manufacturers do not need to disclose the contents.2,3

Recently, concern has been raised about the presence of Tributyl Tin (TBT) in disposable nappies. Greenpeace and Women’s Environmental Network have commissioned research which showed that there were significant levels of TBT in many brands of disposable nappy, including those on sale in the store that the family may be in contact with up to 3.6 times the WHO’s estimated tolerable daily intake. TBT is an environmental pollutant which is used in anti-fouling ship paint. It is known to disrupt the endocrine and reproductive systems. It is known to increase the skin temperature that may impact on fertility and general health. The disposable nappy consists of a plastic outer layer, a layer of superabsorbent chemicals and inner liner. Nappies are not subject to government controls or independent testing and disposable nappy manufacturers do not need to disclose the contents.3

Recently, concern has been raised about the presence of Tributyl Tin (TBT) in disposable nappies. Greenpeace and Women’s Environmental Network have commissioned research which showed that there were significant levels of TBT in many brands of disposable nappy, including those on sale in the store that the family may be in contact with up to 3.6 times the WHO’s estimated tolerable daily intake. TBT is an environmental pollutant which is used in anti-fouling ship paint. It is known to disrupt the endocrine and reproductive systems. It is known to increase the skin temperature that may impact on fertility and general health. The disposable nappy consists of a plastic outer layer, a layer of superabsorbent chemicals and inner liner. Nappies are not subject to government controls or independent testing and disposable nappy manufacturers do not need to disclose the contents.3

The superabsorbent chemicals used include sodium polyacrylate crystals which form a gel in contact with urine. This gel can be seen on the skin in contact with it and there are particular concerns about this entering the body through broken skin in the nappy area. Sodium polyacrylate, along with other chemical constituents that increase absorbency, has been removed from tampons as it was associated with the development of Toxic Shock Syndrome. The inner liner has previously been shown to contain nonylphenyl ethoxylate, which acts as an oestrogen mimic, and dioxins.1

In addition, the use of disposable nappies has important environmental consequences which may impact on child health. Manufacture of disposable nappies uses 3.5 times more energy, 8 times as many non-renewable resources, and 90 times as many renewable resources when compared with washable nappies. The description of such nappies as “disposable” is misleading. In this country, nappies make up approximately 4% of household waste (800 000 tonnes per year) and every disposable nappy and its contents ever used is still present in a landfill site.4

There are environmentally friendly and safe alternatives to the disposable nappy. Modern washable nappies are very different from the traditional idea of buckets of “terries”. There are now shaped cotton nappies with velcro fastenings, alternatives to nappy pants, breathable covers, and disposable paper inner liners. Concern that the incidence of nappy rash is higher with washable nappies is unfounded—it has been shown that it is the length of contact of urine with the skin that is most important in the development of nappy rash and it may be that an infant in a disposable has more chance of developing nappy rash as they are often changed less frequently than an infant in washable nappies. In addition, there are cost savings both to individuals and organisations using washable nappies, and there have been several successful hospital projects using washable nappies on postnatal wards.5

As paediatricians committed to the health of children, we should be aware of the issues raised by the use of disposable nappies, the alternatives that exist, and sources of information and support for parents who are concerned about ensuring a safe and sustainable future for their children.

C HEAL
C COOPER
Consultant Paediatricians,
Royal Albert Edward Infirmary, Wigan Lane,
Wigan W71 2NN, UK

1 Partsch C-J, Aukamp, Sippell WG. Scrotal temperature is unfounded—it has been shown that it is the length of contact of urine with the skin that is most important in the development of nappy rash and it may be that an infant in a disposable has more chance of developing nappy rash as they are often changed less frequently than an infant in washable nappies. In addition, there are cost savings both to individuals and organisations using washable nappies, and there have been several successful hospital projects using washable nappies on postnatal wards.5


Notice of duplicate publication


The same data, resulting from a single pilot study were reported in the two above papers. The authors have apologised, explaining that they had not intended to flout accepted academic standards, rather that they wished to bring their findings to the attention of two separate readerships—namely paediatricians and nurses. However, we would not wish compilers of systematic reviews to include these data twice and therefore we give notice of duplicate publication and withdraw the article published in Archives of Disease in Childhood.