Letters to the editor

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Hypoglycaemia and hypothermia due to nimesulide overdose

Editor—Although toxicity due to chronic administration of nimesulide has been reported,1 to the best of our knowledge there is no report about poisoning due to a single ingestion. We report a 20 month old boy who accidentally took a high dose of nimesulide; 40 mg/kg, 8 times the recommended daily dosage.

Physical examination was unremarkable. Laboratory findings, including hepatic and renal function, were normal, except for low to borderline glucose concentration (3.27 mmol/l) and mild acidaosis (pH 7.35, bicarbonate 16.9 mmol/l). Gastric lavage with activated charcoal was performed. One third N saline in 5% glucose (1500 ml/m2/day) and ranitidine were started intravenously, and he was admitted to our intensive care unit. After eight hours, serum glucose concentration was 3.44 mmol/l, venous pH 7.28 and bicarbonate 18.5 mmol/l. His systolic blood pressure and body temperature fell to 60 mm Hg and 18.5 mmol/l. His systolic blood pressure and body temperature fell to 60 mm Hg and 18.5 mmol/l. Body temperature and blood pressure rose and 20 hours after admission all laboratory findings were normal six days after discharge.

The most striking events in our patient were the development of hypotension and hypothermia. Hypothermia has been reported due to non-steroidal anti-inflammatory drugs overdose, but hypothermia due to the antipyretic action of nimesulide has not been reported. Nimesulide produces a dose dependent antipyretic action in rats by inhibiting COX-2, but its effect under normothermic conditions is not known. Although it has been reported that nimesulide might be given to children with hypoglycaemia, it may cause hypoglycaemia in high ages.

We advise frequent monitoring of vital signs and being alert for hyponatraemia and acidosis in managing acute nimesulide overdose.

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Port-A-Cath use in refractory seizure disorders

Editor,—The use of a totally implantable venous access system (Port-A-Cath) in children has become widespread in the last 15 years. We report a series of three children for whom the Port-A-Cath improved management of their refractory seizures.

Two patients both females with a diagnosis of severe myoclonic epilepsy of infancy and recurrent status epilepticus presented in the first year of life. Both had seizures, which were intractable to multiple anticonvulsants and became refractory to benzodiazepines. Intravenous access was necessary for the third patient, a 3 year old boy with a refractory seizure disorder and their families. This was removed after a total of 4 years; the device has just been inserted. The third patient had no report about poisoning due to a single ingestion. We report a 20 month old boy who accidentally took a high dose of nimesulide; 40 mg/kg, 8 times the recommended daily dosage.

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it can be familial suggesting a learnt behaviour, or developmental and emotional issues may be involved. In America it is classified as an eating disorder, in the UK it is considered a behavioural disorder; it can also be an obsessive-compulsive disorder, or a manifestation of depression.

Our children could shed no light on their compulsion. In six cases the parents found the behaviour so unacceptable that they requested psychological intervention and in four, the behaviour has now stopped. Thus whilst we find this behaviour fascinating, we are no clearer in understanding the aetiolo-gy of pica for sponge in this small population of children with SCD.

Maternal nutrition and pregnancy outcome

Editor,—Symonds et al raise interesting issues about the potential use of animal models to examine the impact of nutrition during pregnancy on future risk of adult disease.1 However, their discussion of recent epidemiological research in humans includes several important factual inaccuracies. The authors imply that our analyses and those of Godfrey et al grouped women into categories of energy intake, and suggest that different results might have been obtained had “all the raw data points [been used] to determine potential relations between maternal nutrition and birth weight”. Yet as clearly indicated in both papers,1,2 this is precisely the analysis that was conducted. For information, figure 1 shows the relationship of birth weight to energy intake in our study. In each paper, the cut points used in tables to illustrate the relationships between energy intake and birth weight were not “unclear” nor “arbitrary” but were, as stated, tertiles. Symonds et al draw attention to the “striking difference” in energy intake between our study and that of Godfrey et al whilst also suggesting that we should combine our data and present the results as energy intake instead of nutritional status. This is concerning for methodological reasons. We do not argue that maternal energy intake can never be associated with birth weight. Under extreme circumstances, such as those in the animal experiments cited by Symonds, or in Third World countries, this may be. However, this is, not basis for suggesting is has any importance to populations in industrialised countries.

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The outcome of specialist registrars in the southwest region

Editor,—The UK national directive is to increase consultant paediatric numbers substan-tially over the next 5–10 years which requires the delivery of suitably trained doctors. Higher specialist training in paediatrics is five years and there is no limit on the current number of trainees who will have the opportunity been available. Female trainees are much less likely to take up this as they view it as compatible with family life.

The southwest regional training committee has expressed concern that trainees are not completely training within five years for a variety of reasons. We therefore reviewed the training times and outcome of the 90 specialist registrars (SpRs) who have trained in our region since the introduction of the Calman training scheme. The high proportion of women entering paediatrics needs to be addressed. Our review confirms that 29% of trainees are training flexibly, which will increase their training time for anything up to 10 years. All these are in the flexible training scheme that requires at least five sessions per week, training times will be even further extended. Also our training committee is concerned that five SpRs have resigned before completing training. Four of these are women who resigned because, despite working part time, they felt that the career process was incompatible with family life.

Generally, the trainees who trained flexibly and who have obtained consultant posts, four have chosen to work as part time consultants. The other two would have done so had the opportunity been available. Female trainees will have the longer to train, both before full-time and also time out for maternity leave. Moreover, every trainee will not necessarily translate into one whole time equivalent consultant. Our region has 47% of trainees are having their Certificate of Completion of Specialist Training (CCST) date reviewed; the average time for them to complete a five year CCST programme based on current calculations is 6.3 years. Reasons include sickness.

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Adrenaline syringes: community perspective

EDITOR.—We read with interest the paper by Unsworth1 regarding the over prescribing of adrenaline syringes. We are sure we are not the only community paediatric team who have similar concerns, although perhaps from a different perspective. Dr Unsworth writes of the safety issues. We have more experience of the practical problems.

Thanks to the availability of prompt training for school staff by community personnel, it is now rare for a child to actually be excluded from school because they have an adrenaline injection device. However, they may very well be excluded from other activities such as guide camp or trips abroad.

There is also the increasing problem of young people with adrenaline injection devices moving on to college or work places. Who should train staff there?

Other problems with adrenaline injection devices in our local community include two being lost on the bus, and one being accidentally fired into the interphalangeal joint of a child’s thumb with the needle becoming bent like a fish hook.

There is also the issue of keeping them in date. Parents often forget to renew them, particularly those kept in school. Whilst it does not need to be kept in a refrigerator, adrenaline does deteriorate in warm conditions, and injection devices should be checked to make sure the adrenaline inside remains clear and colourless.

Often, an adrenaline injection device has been prescribed with no demonstration to the child or family on how to give it, nor when to give it. Surely antihistamine should also be prescribed in every case? In most children, it is the only medication, which is going to be needed. However, it is left to chance instructions on when to call an ambulance. They could easily make the mistake of trying to take a deteriorating child to hospital in their own car, instead of calling an ambulance. However, even assuming that they do not need to go to hospital at all if they have given adrenaline. As Dr Unsworth points out, the adrenaline injection does not always save the child’s life.

We would suggest that when an adrenaline injection device is prescribed it must be demonstrated to both the parent and child (if the child is old enough). A dummy pen is helpful for this. Demonstration should be repeated with each repeat prescription of the device. The child and their family should always have a written management protocol, including instructions on expected symptoms, when to give antihistamines and when to call an ambulance, and when to give adrenaline. Such a protocol can then be passed rapidly to the community paediatric team to support the prompt training of school staff.

It is worth remembering that clinical responsibility for the safe administration of a drug rests with the prescriber.

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1 Unsworth DJ. Adrenaline syringes are vastly over prescribed. Arch Dis Child 2001;84:410–11.

Controversies in paediatrics?

EDITOR.—I was very disappointed to see that the first contribution to the Controversy series was not written by a paediatrician. There are plenty of controversial topics in paediatrics, including the one cited. There are also plenty of paediatricians perfectly qualified to be involved in the written debate about them, again including the topic cited. The absence of a contrasting viewpoint in the same issue suggested to me the feature should be called “Opinion” rather than “Controversy” because the article is not a balanced review of the current state of allergy practice.

The BPA and latterly RCPCH have championed for decades the holistic approach to the care of children. Paediatricians are best placed to assess the integrated needs of a child with medical problems. This principle is very relevant to developing areas of specialisation in which there is short supply of expert advice, such as in allergy. Paediatric allergists assess the impact of the diagnosis on many non-medical facets of a child’s life, including family lifestyle, integration into schools and peer groups, and the facilitation of appropriate independence from parental supervision. It is tiring to have to rehearse the arguments for the appropriate protection of subjects at risk of anaphylaxis. Epinephrine (as all doctors should now be calling adrenaline) is not prescribed in children or families with an allergic child. It is part of the integrated management plan, which appears to be effective though difficult to measure.

It is very hard to prove that epinephrine saves lives but I agree that the notion “number needed to treat” with epinephrine to prevent a death from anaphylaxis is very high. Unsworth’s title suggests that this “very high number” (my phrase) is too high. How has he measured that? What is too many? He quotes a prevalence of about 1% of American children having peanut allergy. That is approximately 3 million subjects. We do not restrict insulin syringes to just a few insulin dependent diabetics because diabetes is so common that we cannot adequately care for all of them. Every allergic child has the right to the best available care, which is not restricted to the first 100 through the clinic door (if they can find an allergy clinic).

Laparotomy will not save every patient with a leaking aortic aneurysm. Antihistamine will not save every person who has anaphylaxis. Anaphylaxis is a critical situation in which prompt administration of epinephrine may (but occasionally may not) save a life. I think it unarguable that it is better to self treat and probably survive than not self treat and possibly die. Unsworth quotes one early paper about anaphylaxis from the US and more recent British data.7 These papers all agree more that than the rarity of deaths. Unsworth’s title suggests that this “very high number” is too high. We do not operate a lenient policy for out of programme experience that will count towards training. No more than one year is allowed except for those entering an MD or PhD programme, and only four trainees have taken more than one year for research prior to CCST. Moreover, we insist that training in locum appointment for training (LAT) posts in our own region in core paediatrics does count towards CCST. Therefore, in other regions where more liberal policies are operated, there are more trainees in research posts, training times may be even longer.

Having obtained their CCST, only half of our trainees have currently obtained consultant posts; 75% of the remainder have sought fellowships abroad, or training elsewhere as post-CCST PhD trainee posts; 75% of the remainder have sought research posts, and the numbers of doctors wishing, there is a considerable discrepancy between the regions where more liberal policies are operated, and the numbers of doctors wishing, there is a considerable discrepancy between the regions where more liberal policies are operated, or training in another specialty. Therefore the total average training time is further extended. The remaining 25% are locum consultants awaiting a suitable post becoming available. All are geographically restricted and some are also specialty restricted.

Our review would suggest that there is a considerable discrepancy between the number of national training numbers issued and the numbers of doctors wishing, or eligible, to take up consultant posts five years later. These issues need to be taken into consideration in manpower planning and in designing the national service framework for the future.

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kits allows normal life to go on, involving school overnight stays at friends, camping, and other normal activities of childhood. Anecdotally, parents seem to me less stressed when they learn clinic with information (however awful the scenarios described) and respect their rights than when they are not. I have never met a parent who reported being more scared of the epinephrine kits than of the prospect of allergen exposure (with or without epinephrine available).

Families must be taught when to use epinephrine and how to use autoinjectors. Until doctors can tell families that anaphylaxis will never happen we should continue to empower families, ensuring they are ready to respond as best they can to the disaster that allergen exposure represents. When anyone develops a real treatment for food related anaphylaxis I can stop prescribing epinephrine kits to people who currently need them.

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Appropriate prescription of epinephrine remains the best available treatment

Editor,—Epinephrine kits enable a food allergic child at risk of anaphylaxis to lead a normal life and participate in childhood activities that could easily be denied by a parent terrified of another allergen exposure. Avoidance of allergens rather than rescue epinephrine therapy is the basis of current management of food allergy. However, unexpected exposures are inevitable. Fifty eight per cent of children followed for five years experienced adverse reactions from accidental peanut exposure.1 Peanut is the most common food allergen causing anaphylaxis and pervades the diet of young children in food processing. Anaphylaxis related to foods most commonly occurs in patients who have had previous severe reactions. However, minor initial reaction does not exclude a subsequent severe reaction to peanut. Any person with anaphylaxis deserves the best available protection. It is reasonable to always have two Epipens available both at home and at school. A second Epipen provides back up if a faulty technique is used or one syringe is damaged. Anaphylaxis may be biphasic, recurring in 3% of children admitted with anaphylaxis.2

As advocates of children, paediatricians are unlikely to hand out epinephrine syringes without due consideration of the impact on the child and his or her family. A comprehensive plan with written information is essential for any child seen with a food allergy whether or not epinephrine is prescribed. Sicherer et al showed 20% of children did not carry epinephrine outside the house and only 55% had unexpired epinephrine on them. However, successful demonstration was associated with repeat prescriptions, membership of a lay organisation for food allergy, and being reviewed by a school nurse. Training packages for schools such as devised by Vickers in Cambridge3 are valuable.

Unsworth states that “Community use should be much more restricted with increased involvement and reliance on trained medical staff”. Food allergy is the most common cause of anaphylaxis in children outside hospital. Early recognition and use of epinephrine is vital for successful outcome. The median time to respiratory or cardiac arrest was thirty minutes in children with diagnosed anaphylaxis in one series.4 Surely this implies that the community is the setting where epinephrine should be given by appropriately trained parents and carers to a food allergic child with signs of anaphylaxis. Parents should be empowered as limited resources prevent medical staff being present immediately. Indeed, epinephrine IV by trained medical staff also appears to be more hazardous than the use of epinephrine by lay patients.5

In the absence of any other treatments for food related anaphylaxis, the considered use of epinephrine kits as part of an integrated management plan is the best choice.

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Reply

Editor,—I was pleased to see that my article provoked lively discussion of this important issue. I am not surprised that patients and families are concerned about poor compliance. I agree with Wolff and Runney that adrenaline should never be the sole prescription. In addition to antihistamines, prednisolone has a place. The idea of a written management plan is a good one.

Hourihane contrasted prescription of adrenaline with provision of insulin syringes in diabetes mellitus. We do not restrict provision of insulin syringes in that context because to do so would inevitably result in hypoglycaemia and ill health in all cases, ranging from coma to retinopathy. The risk benefit ratio is clearly in favour of daily insulin use. By contrast, the “very high” number of adrenaline prescriptions for schools such as that devised by Vickers in Cambridge3 are valuable.

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1 Unsworth DJ. Adrenaline syringes are vastly over prescribed. Arch Dis Child 2001;84:410–11
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