Emergency asthma inhalers in schools

We were interested in the review by Reading and colleagues.1 In Wolverhampton we are fortunate in having had a school asthma policy in place since 1994 which includes supplying emergency inhalers to schools for use when the pupil’s own inhaler is not available.

The policy was initiated by two hospital paediatricians with an interest in asthma and was quickly incorporated into the local Respiratory Care Group. The involvement of enthusiastic school nurses with a special interest and training in asthma and the support of the community paediatricians have been invaluable.

Initially, an approach was made to the Director of Education who was of the view that giving inhaled treatment to known asthmatics could be considered to fall within the school staff acting in loco parentis. Every state school in the borough was offered a visit from a hospital paediatrician and a children’s asthma nurse to present the theory and practise of using emergency asthma inhalers. Every school was supplied with a short acting β agonist (pMDI plus spacer), a protocol including dosage, and authorisation signed by a hospital paediatrician, community paediatrician, and the lead school nurse for asthma. An annual update is given to the school nurses and they (or the lead school nurse) in turn annually train or retrain the school staff as required.

Pupils with asthma are identified by the school nurse and each child given an individual asthma card with their emergency treatment detailed. Written consent for a named pupil to be given the emergency inhaler is obtained from the parent and authorised by a paediatrician. This is in effect the prescription. These individual, but standard, health care plans for children with asthma are not “a logistic nightmare” but straightforward to administer and conform to the joint health and education guidelines for supporting pupils with medical needs in schools.2

A school nurse led audit in 2003 confirmed that all schools held a register of use, with a named person from the school staff being designated by the head teacher.

Although our policy may not comply strictly with the letter of the law, there is clear clinical responsibility and we ensure that all children with asthma have ready access to emergency treatment in school.

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Bleeding ethics

The EarlyBird Diabetes Study started recruitment of 300 children in January 2000, and at the time of writing has entered phase II of its four planned phases. It is halfway through seeing the children for their seventh visit and retains 92% of the original cohort. The study takes venous blood samples annually, and has done since baseline when the mean age was 4.9 years. A selection of publications dependent on these blood samples is listed below.

UK colleagues have sometimes queried the ethical justification for taking blood from healthy children so young, suggesting that their own ethics committees would be unlikely to give approval. Ethics committees are there to protect the vulnerable, but their deliberations are not automatic, and it is important that this be guided by sound evidence as well as good sense. The aim of this letter is to reassure our own and other ethics committees that venepuncture causes little, if any, distress to young children, that it is safe, and that the information obtained can be substantial and useful.

The parent’s written consent at the start, and the child’s assent on each occasion, are obtained. An anesthetic cream (Emla) is applied at least one hour before the blood test, which makes the process virtually painless. The child’s attention is averted by a slide viewer, and the paediatric nurse is expert. Very few children ever refuse, the majority are blasé, and some even choose to watch. To date, we have attempted 1057 venepunctures. Only 29 attempts—fewer than 3%—failed, mainly for technical reasons.

With a three year experience of taking blood daily from young children, we have experienced no reaction from the study participants that might deter an ethics committee from endorsing venepuncture. The insertion of a needle into a properly anaesthetised arm is a minimal and safe intervention.

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Much of this information can be gleaned from microbiology texts, but the sections are generally very well written and up to date. Toxoplasma for example, being covered very well with excellent diagrams and illustrations. A useful little chapter describes the laboratory manifestations of infectious diseases, for example listing infections commonly associated with an ESR >100 mm, or infections which cause a monocytosis or a myeloid leukemic reaction. The book concludes with helpful chapters on anti-infective therapy.

This work is succinct yet surprisingly detailed for a single volume textbook; it will be very useful for the specialist and trainee in paediatric infectious diseases, but also for the general practitioner who wants to quickly check, for example: what infections could be causing the fever in a child with sickle cell disease, what might be the causes of lymphadenopathy in a recently returned traveller, or what are abscesses. The discussion on anti-viral therapy is particularly good. Perhaps I ought to send a copy to the person who gave me the careers advice a quarter of a century ago!

A Cant

Clinical paediatric nephrology, 3rd edition


Since its first publication in 1986, Clinical paediatric nephrology has been the reference textbook on the subject that seems to create a great deal of anxiety in general paediatric departments. This, the third edition, is truly comprehensive and provides extremely clear, child focused guidance to any professional interested and involved in paediatric care. It represents a total rethink of the last edition which was published in 1994. Its attractive red and yellow book cover, with the charming schoolgirl drawings about a child in hospital contrast with the earlier scanning electron micrograph of a normal rat glomemular capillary loop and dramatically announce these differences. Nicholas Webb now joins Robert Postlewaite as editor and the number of contributors, all internationally well known in their field, has increased to 50. The second edition’s 32 chapters and 398 pages have been completely revised and rewritten, providing this edition with 28 chapters and 509 pages.

The chapters all follow a problem solving approach, focusing on presenting clinical symptoms in the child. Whether you are a general practitioner, paediatrician, nephrologist, urologist, or intensivist, trainee or qualified, doctor or even clinical nurse specialist, the clear algorithms simplify even the most daunting problems. All chapters are referenced and where evidence is lacking or controversy exists, a clear “take home” opinion is provided. Layout and typography are clean, clear, and structured, while key point boxes highlight important messages. Illustrative case histories further emphasise the guidance provided. Up to date information is provided on all common renal and urological presenting symptoms. “How and when to measure blood pressure” is an essential read for anyone examining a child. In “Imaging in paediatric nephrology” the reader is reminded that liaison with the clinical team involved in managing the child is paramount. Rather than dwell on complicated algorithms for investigations of common problems, this chapter reviews each investigation in detail. Dosimetry, a subject that many parents ask about these days, is also covered. The words “nephrotic” and “nephritic” often raise apprehension among non-nephrologists. Even Microsoft Word spell-checker rejects the word “nephrotic” in favour of “nephritic”. In this edition, two relevant chapters help in understanding all aspects of these two presenting problems. “The child with nephrotic syndrome” combines two chapters from the previous edition to facilitate practical use, and this is successful, although case studies would have been interesting here. “The child with acute nephritic syndrome”, a new chapter, together with “The child with acute renal failure”, illustrates guidelines for drug prescribing in children with renal disease provides information not readily available elsewhere. The chapter relating to “Paediatric nephrology in developing countries” is a concise and yet very comprehensive new chapter, well illustrated with seven case examples. “Meeting the information needs of children and their families” brings this textbook into the 21st century and the three appendices are an invaluable and accurate resource. “Practical guidelines for drug prescribing in children with renal disease” provides important reference data for paediatric nephrology, and the list of abbreviations at the beginning of the book is very useful.

Anyone involved in the care of children should ensure that this book is readily available for reference in their department library or clinical area. It is an invaluable resource companion, and while there is a current trend in paediatric textbooks to present topics in a “child focused” rather than an “academic manner”, this third edition follows that trend but does it rather better than the others.

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