The launch of the British National Formulary for Children

A Elias-Jones, G Rylance

A definitive formulary

On 14 July 2005, the official launch of the British National Formulary for Children (BNF-C), attended by HRH Princess Anne, was hosted at the Royal College of Paediatrics and Child Health (RCPCH).

This definitive formulary is the result of cooperation between the British National Formulary team (BNF) and the team that produced the Medicines for Children (MIC) books whose second editions were published in September 2003.

There has been a clear recognition that children have been disadvantaged by the requirement to receive medicines not licensed for use in children or off label applications. Studies have shown the problem to be worse still in neonatal practice where up to 93% of babies receive at least one unlicensed or off label medicine during their stay in intensive care. The use of unlicensed drugs and off label carries significant risks highlighted in many publications.2,3

Hence, the first edition of Medicines for Children was published by RCPCH Publications Ltd in 1999. The work involved in producing the book was an immense achievement and involved the cooperation of many paediatricians with expertise in paediatric prescribing and members of the Neonatal and Paediatrics Pharmacists Group (NPPG) under the supervision of the RCPCH Medicines Committee chaired by Professor Sir David Hull. The pocket book edition followed in 2001. These books have rapidly become established as the definitive prescribing books for neonates and infants and continue to be used by many practitioners who have no direct experience in paediatrics.

The main aim of the BNF-C was to provide clear, concise, up-to-date information for practitioners about medicines which can be used in children. A major factor in achieving this aim was to standardise the format of the information in the MIC books. The BNF-C has followed the same format as the standard BNF so that users of both publications will follow the same format. It has ensured that the information is accessible by being in an electronic version, available on CD-ROM and online via the BNF- C website.

The BNF-C website was launched in October 2005. A new page format and colour highlighted text for clarity and easy accessibility may lead the way for the BNF to follow. The long wait for a much needed electronic PDA version of the major British paediatric prescribing guide should end in about September/October of this year. The ease of use of an alphabetical listing of drugs will be practically realised in the PDA version, though not in the book. The Department of Health, in addition to supporting this publication, is encouraging the development of a BNF-C website with increasing sophistication over time to assist timely, accurate, and error free prescribing.

The production process involving in-house BNF-C staff (four whole-time equivalents and the editor) in preparing Notes and Drug Monographs relieves adviser/writer paediatricians and pharmacists of the time consuming task of generating text information. Expert advisers now only need to comment on respective sections and make suggestions for inclusions/changes in future editions according to peer experience, practice, and new literature. Dedicated sub-editing teams allow advisers to consider clinical validity and accuracy rather than minutiae. The first edition this year incorporates the best of MIC and the BNF, in-house literature culls, and adviser recommended new information. It has afforded the generation of an evidence database more comprehensive and secure than was the case for MIC. It is hoped that BNF-C will meet all professional needs, but serving the interest of quite different users is a difficult task. Time constraints have meant that the first edition BNF-C reproduces the layout of the BNF, and the optimum presentation for the longer term future has not yet been determined. This, and the fact that success cannot be measured by sales figures, is why feedback of user views will be so important. There will be an insert for this purpose to return views on paper or electronically using the same form via the website. If opinion demonstrates that a different format, style, and content approach is indicated for future editions, changes will be considered and accommodated where possible.

BNF-C will be different from MIC. Distributed free to all doctors, pharmacists, and dental practitioners, it will have an enlarged and perhaps different readership—neonatologists and general practitioners were infrequent users of MIC. BNF-C is designed to meet their needs as well. From the BNF stable, it will follow the same format as the standard BNF so that users of both publications will find it easy to use. However, there will be significant differences. A new page format and colour highlighted text for clarity and easy accessibility may lead the way for the BNF to follow. The long wait for a much needed electronic PDA version of the major British paediatric prescribing guide should end in about September/October of this year. The ease of use of an alphabetical listing of drugs will be practically realised in the PDA version, though not in the book. The Department of Health, in addition to supporting this publication, is encouraging the development of a BNF-C website with increasing sophistication over time to assist timely, accurate, and error free prescribing.

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Lord Warner also announced that part of the funds allocated in the Budget were to be directed to the Medicines for Children Research Network (MCRN), which is part of UK Clinical Research Network. Since then, a consortium from the University of Liverpool, Royal Liverpool Children’s Hospital, Imperial College London, The National Perinatal Epidemiology Unit (University of Oxford), Liverpool Women’s Hospital, and The National Children’s Bureau have established the Coordinating Centre for the MCRN.
It is planned to produce a new update edition each year—half as frequent as the BNF.

The BNF in its present format is 50 editions old this year. Here’s to the first BNF-C.

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REFERENCES

IMAGES IN PAEDIATRICS

Cutaneous larva migrans, creeping eruption, sand worm

Cutaneous larva migrans is the most common tropically acquired dermatosis. It is characterised by erythematous, serpiginous, pruritic, cutaneous erosion caused by percutaneous penetration and subsequent migration of larvae of various nematode parasites. It is most commonly found in tropical and subtropical geographic areas; however, because of the ease and the increasing incidence of foreign travel by the world’s population, cutaneous larva migrans is no longer confined to these areas.

We report a 2 year old girl who presented with a four month history of itchy rash on her thigh. There was a history of travel to Jamaica before the onset of the rash. She had a serpigenous, erythematous, itchy rash on the back of her right thigh. She was successfully treated with thiabendazole.

The larvae of the dog hookworms *A braziliense*, *A caninum*, and *U stenocephala*, together with certain other parasites, produce in humans a skin eruption which differs from that caused by “human” hookworms. Most infections are due to *A braziliense*. Infections occur on sandy bathing beaches, in children’s play areas, and by contact with pet sandboxes. Lesions are most common on the lower legs and buttocks, but also occur on the arms, hands, and face.2

The larva, after penetrating the epidermis, is unable to enter the blood or lymph streams and instead burrows just below the corium, travelling up to an inch a day. Papules mark the site of entry and advancing end of the larva, and the tunnelling causes linear, slightly elevated erythematous and serpigenous areas which itch intensely. Vesicles may form along the course of the tunnels and scaling develops as the lesions age. They may develop secondary bacterial infection. The most common sites in children are the buttocks and the dorsa of the feet, but any area can be affected. The eruption generally disappears after 1–2 months, but may present for 6 months or longer.

Treatment

The time honoured treatment for cutaneous larva migrans is by freezing of the area with ethyl chloride or similar refrigerant sprays. Diethylcarbamazine or thiabendazole can be used. Thiabendazole can also be used topically.3

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Consent was obtained for publication of this figure

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