LETTERS

ALTE and gastro-oesophageal reflux

McGovern and Smith¹ have embarked on the welcome development of an evidence based algorithm for the investigation of infants presenting with an apparent life threatening event (ALTE). Unfortunately, they do not distinguish between coincidence and causality. Recurrent vomiting occurs in over 60% of 4 month old babies, and it is therefore unsurprising that gastro-oesophageal reflux is commonly found in infants presenting with ALTEs. The aim of their study was to determine the diagnoses reported after the first evaluation of an ALTE; but the paper’s title then somewhat misleadingly refers to “causes” of ALTE.

Despite the fact that in six of the eight studies analysed, patients did not routinely undergo pH monitoring, one of the most common diagnoses made was “gastro-oesophageal reflux disease” (GORD). This begs the question as to whether most if not all of the children merely had physiological gastro-oesophageal reflux (GOR), wrongly defined as GORD, simply because of the ALTE under investigation—an unwarranted assumption of causality. Moreover, they fail to point out that the milk scans and contrast studies used in some of their cited studies have unacceptable low sensitivity and specificity in the diagnosis of non-physiological GOR.

Their suggested plan of investigation acknowledges that in around 50% of infants experiencing an ALTE, a careful history and examination will point to an underlying diagnosis. Conversely, in the absence of other symptoms (for example, vomiting) they imply it may be important to identify and treat occult reflux by recommending investigating for GORD. Demonstration of a significant temporal relation between lower oesophageal acidification and apnoea is crucial in establishing a causal hypothesis linking the two. However, in an ALTE under investigation—an unwarranted assumption of causality. Moreover, they fail to point out that the milk scans and contrast studies used in some of their cited studies have unacceptable low sensitivity and specificity in the diagnosis of non-physiological GOR.

Most of the studies in this review did not diagnose GORD by the accepted criteria. The issue of causality was not addressed and it is therefore not necessarily temporal.¹ Given the current state of conflicting evidence, it would seem reasonable to investigate the upper gastrointestinal tract according to our algorithm (see discussion below). We agree that the paper could be titled “Diagnoses reported after apparent life threatening events in infants: a systematic review”. The abstract, however, summarised the aims, results, and conclusions of the review.

We have not advocated a blanket investigation for GORD in all ALTEs. We have designed our algorithm with several selection points. The algorithm indicates that if the patient does not have a short, self-correcting episode around feeding (often physiological GOR), then a period of observation (including a review of history and examination) is indicated. Then, if the history suggests GORD, appropriate testing is performed. This is no different from the approach suggested by Drs Puntis and Booth. If no cause is forthcoming and the clinician is concerned about the event, we do recommend a series of investigations, which include investigation of the upper gastrointestinal tract. Perhaps the algorithm would be more accurately written as investigation of the upper gastrointestinal tract instead of investigate for gastro-oesophageal reflux to acknowledge the possibility that anatomical abnormalities of the gastrointestinal tract may present with an ALTE.

The problem of ALTEs is one faced daily by frontline clinicians. The purpose of our review was to try to bring some clarity and order to conflicting literature. We view this paper as a starting point for an evidence based approach. We invite further discussion.

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References

Authors’ reply

We appreciate the thoughtful comments on our recent paper. The main points raised by Dr Puntis and Booth are:

- Most of the studies in this review did not diagnose GORD by the accepted criteria
- The issue of causality was not addressed
- They recommend investigating for GORD only when there is corroborating clinical information because occult reflux does not cause apnoea.

We agree that the diagnosis of GORD disease requires a combination of clinical information and selective testing. We acknowledged in our paper that there were varying investigative protocols for this disease. We were unable to review the diagnostic criteria for all studies. This reflects the lack of one standardised, well validated test. pH probes have limitations as well because they do not detect non-acid reflux. The clinicians in the studies reviewed reported GORD as a diagnosis after an ALTE but did not say it caused the ALTE.

The issue of causality was clearly addressed in the discussion and we agree that it is a very important point for exactly the reasons which Drs Puntis and Booth highlight. To repeat, we have said that the detection of a disorder after an ALTE does not necessarily mean that the two are associated. We noted that there was conflicting evidence as to whether or not the relation between GORD and ALTEs is causal. Even when an underlying disorder such as RSV infection (which seems to have a clear temporal relation with an ALTE) is detected, the question is still unresolved as to why some infants react to RSV infection with apnoea while others do not.

It is likely that several factors interact to produce an ALTE. We do not think the relation between GORD and apnoea has been clearly established in the medical literature. Drs Puntis and Booth write that demonstration of a significant temporal relation between lower oesophageal acidification and apnoea is crucial in establishing a causal relation between the two. However, in an editorial review of GORD and infant apnoea, it is noted that GORD and apnoea may have a causal relation that is not necessarily temporal.¹ Given the current state of conflicting evidence, it would seem reasonable to investigate the upper gastrointestinal tract according to our algorithm (see discussion below). We agree that the paper could be titled “Diagnoses reported after apparent life threatening events in infants: a systematic review”. The abstract, however, summarised the aims, results, and conclusions of the review.

We have not advocated a blanket investigation for GORD in all ALTEs. We have designed our algorithm with several selection points. The algorithm indicates that if the patient does not have a short, self-correcting episode around feeding (often physiological GORD), then a period of observation (including a review of history and examination) is indicated. Then, if the history suggests GORD, appropriate testing is performed. This is no different from the approach suggested by Drs Puntis and Booth. If no cause is forthcoming and the clinician is concerned about the event, we do recommend a series of investigations, which include investigation of the upper gastrointestinal tract. Perhaps the algorithm would be more accurately written as investigation of the upper gastrointestinal tract instead of investigate for gastro-oesophageal reflux to acknowledge the possibility that anatomical abnormalities of the gastrointestinal tract may present with an ALTE.

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Reference

Diagnosis of iron deficiency anaemia

According to Wright et al, taken in isolation, a mean cell haemoglobin (MCH) of <25 pg is
more likely to predict a significant haematological response to a trial of iron replacement therapy than a mean cell volume (MCV) of <75 fl, on its own. My own approach to identifying which of the two red blood cell indices, namely MCH and MCV, was the stronger predictor of iron deficiency was to evaluate the cut-off levels which yielded the optimum combination of sensitivity, specificity, and positive predictive value for unequivocal iron deficiency, the latter being defined as a serum ferritin of <10 μg/l. In a study comprising 365 adults characterised by an MCH of <26 pg and/or an MCV <80 fl, 145 of whom proved to be unequivocally iron deficient,1 it is clear that the one associated with the optimum combination of sensitivity (74%), specificity (59%), and positive predictive value (80%) for this diagnosis. Correspondingly, an MCV <76 fl was the one associated with the optimum combination of sensitivity (65%), specificity (66%), and positive predictive value (55%). Fortuitously, in the ABC of clinical haematology, it is also an MCV of <76 fl which is utilised in what I would describe as “automated” screening for iron deficiency.4

However, what has not been addressed until very recently, is the issue, not only of the suitability of MCH in predicting a favourable response to a therapeutic trial of iron replacement therapy,5 but also its robustness, relative to the MCV, under laboratory conditions of automated screening. According to one of the leading authorities on the subject, different counting devices yield “clinically significant different” estimates of the MCV, as shown by the monthly reports of the UK General Haematology NEQAS Scheme. In contrast, MCH yielded a “consistent equality of results reported by the different technologies within the UK NEQAS schemes”5. These observations tend to support the suggestion made by the authors of the present study that, as opposed to the MCV, the MCH should be the preferred screening test for predicting a satisfactory haematological response to iron replacement therapy.4

Revisiting mercury sphygmomanometer in paediatric clinical practice: is there a need for a consensus conference?

The definition of normal blood pressure (BP) values in adolescence is based on mercury sphygmomanometry, and standard mercury readings are the main basis for BP-disease associations.6 Unfortunately, mercury has toxic effects on the environment and the mercury sphygmomanometer is likely to have to be gradually replaced.4 However, there is a rearguard movement to retain mercury until some satisfactory substitute can be found.7

We investigated the type of BP devices that are currently being used in Departments of Paediatrics in Greece. In a total of 76 departments, 30% use a mercury sphygmomanometer, 25% use automated devices, 25% use either mercury or automated devices, and 20% use an aneroid sphygmomanometer. Interestingly, 1 in 3 departments has the commonly used automated monitor “Dinamap” (several models); furthermore, half of these departments are using the model 8100. Kruger et al.7 validated the accuracy of Dinamap monitors is questionable, especially the model 8100, when tested against the standard mercury sphygmomanometer, was found to detect mean systolic and diastolic blood pressures significantly above auscultatory readings.7

We feel that replacement of mercury sphygmomanometer with automated devices has become increasingly common but, also, rather questionable in some countries, considering the lack of validated automated devices for the paediatric age group. The recent “International Protocol” established by the European Society of Hypertension for validation of BP measuring devices, is designed for adults and does not make recommendations for children.4 Facing the beginning of new standard in clinical sphygmomanometry, there is little doubt that we need a consensus conference. Such a conference would help in making recommendations for endorsing the use of alternative devices as the optimal replacement for mercury devices. Furthermore, the development of appropriate validation standards for paediatric use of BP devices and the elimination of inaccurate monitors would improve our methods of BP measurement and interpretation.8

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Competing interests: none declared

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References


In contrast to a decade ago, there appears to be numerous paediatric “textbooks” on the market today, aimed primarily at medical students. The choice must appear somewhat overwhelming! Core paediatrics adds itself to this ever-growing list. As the title suggests however, it does attempt to approach the subject from a different angle.

The book is set out in 40 distinct chapters. Each chapter approaches a familiar topic in a refreshing manner—likely to appeal to a student and in a way in which they can place it in context. For instance, there is a chapter on “Upper airway obstruction”, Core paediatrics presents this as “A boy with a coughing fit” or “A tired teenager”, and so on.

The authors present each chapter in a systematic manner. A clinical case is presented—many of which the typical student is likely to encounter on any paediatric attachment. Realistic differential diagnoses are then presented, the same way in which a junior doctor may formulate impressions after clucking such a child. The authors then go on to consider each of the differential diagnoses at length, taking into account aetiology, pathology, investigations, and management. Frequently, the text pauses to present the reader with “Self-tests”: These questions are relevant to the clinical case and many are typical dilemmas that doctors face in planning management for unwell children. Some are presented as extended matching multiple choice type questions.

The authors stress the importance throughout—of history and examination, and guide the reader in eliciting key facts in the clinical cases. Throughout the book, information is presented in easy to read tables and diagrams, which appeal and break up the text. Relevant investigations are discussed at length, often with illustrations. Dilemmas are often centred around such investigations—for instance, how should a urine sample be obtained from young children when investigating for UTI? Further questions relate to interpretation of such investigations—ensuring a clinically relevant approach. Throughout the text, misleading “normal” test results are discussed as well as obvious positive test results. Management of various conditions is presented in a structured way, incorporating both immediate and long term issues. When relevant, drug doses are included—useful for junior doctors, as well as other tips such as writing child protection medical reports. The book addresses the issue of management around clinical cases, presenting likely progress that a child may make...
A pleasant feature of this software is the use and access to the Main Index), tools, and help. The bottom of the page is to edit (make annotations). The menu at the top, along the right side, and on the bottom comes with an internal link to other Skyscape products that are already installed on your PDA.

Have you ever wondered, looking at Wisteria, if the plant in front of you is right or left winged? Do you know how to tell? Once you know, it is easy. It is just the same with this publication. This is not a book, not even an eBook. Chief complaints in pediatrics is software. It is worth clarifying this right at the start, as there are some practical consequences to this. After installation you will find its icon in the list of programs. If you simply follow the prompts, it will install itself to the main memory. If you then realise that you want to have it on your memory card you will have to go through uninstall and install (to the chosen location) procedure. As this is not a book, there are no numbered pages.

The interface is easy and intuitive, you will be able to do it all without looking into Help. The same unified interface can be found on all Skyscape products; if you have used any other Skyscape products, you will find the familiar interface of the program. Chief complaints in pediatrics deals with the common problems. It will be most useful as a diagnostic aid and does not contain any information about treatment or prognosis.

In summary: the program works really well, is easy to use, and very functional. My only reservation is that many paediatricians would find it too content. For a trainee it seems a good investment.

E Posner

Pediatric physical diagnosis electronic atlas


Today, medical education faces huge challenges. The patient contact time essential for developing clinical acumen has been progressively eroded by increased trainee numbers, reduced working time, reduced training duration, shifts, and encroachment of non-medical professional and non-medical medical areas. Skills labs have evolved to cover basic skill sequences, but there remains a gap between core skills and clinical practice. An obvious approach is to “can the experience”, using modern multimedia technology to bridge the hiatus, ensuring some exposure at least to core conditions. There are various ways of developing such collections: the proprietary way, as here, or by using the internet, as for example at www.brisho.ac.uk/bbh, www.hon.ch/HONmedia, www.healthcentral.org, or www.peir.org.

This single DVD comes in a large glossy box with significant dead space. The authors are American, mainly from the Children’s Hospital of Pittsburgh. The resource consists of “over 2500 visual representations of a broad range of common and uncommon pediatric disorders”. There are over 40 video and audio clips too. The images can be saved to a separate area (like a shopping trolley on the web), then transferred to PowerPoint. The video and audio can be navigated to on the disc and transferred using cut-and-paste. The licence does not allow materials to be integrated into other teaching resources (for example, question banks), nor can the PowerPoint presentations be placed on the web or intranet. Images can be viewed without annotation, but there is no inter-active self-assessment (that is, scoring or review of wrong answers).

The term “physical diagnosis” is used broadly, and is not restricted to clinical signs. For example, x ray pictures, blood films, karyotypes, and diagrams are all included. It also includes many normal children, for example in the section on child development. The resource quality is generally good to excellent, with most images presented as full colour JPGs. The highlights for me were the video clips of different forms of epilepsy. These bring to life an otherwise difficult topic. I was a little disappointed with the quality of some of the heart sounds. Coverage is inevitably incomplete: for example, there were excellent radiographs of pneumocystis, mycoplasm, and tuberculous pneumonias, but none of typical lobar pneumonias or bronchiolitis.

Searching is rudimentary, either by one of 23 chapter headings and scrolling through the thumbnails or by using a simple search string (US spellings) through the annotations. There is no metadata, but audio/video files can be accessed separately using tabs. This means that there is a learning curve associated with using the resource effectively with the potential to miss media that are in it. With repeated use its value increases greatly.

It is an excellent and reasonably comprehensive resource for an antidepressed to have available for teaching purposes, particularly those with slow or difficult internet access. A huge amount of work has gone into its production and the authors are to be congratulated. It provides a good way to learn most classical presentations for examinations, particularly DCH and Part 2, though the text version may allow for a more structured approach. I shall certainly be using it for my own teaching. I suspect that the restrictions of DVD capacity, publishing cycle (versioning), searching, and copyright will prove to be long term disadvantages compared with the web based approach. It is worth remembering that, while multimedia are useful they are no substitute for the “real thing”. The clinical experience engages the whole brain at sensory, intellectual, cerebel-lar, and emotional levels. We are still far from virtual reality here, but this resource is certainly an advancement on a traditional textbook with text and few illustrations.

C Melville

The treatment of gait problems in cerebral palsy


I settled down to read this book, thinking it would be instructive and enjoyable—and I was not disappointed. Basic principles are clearly explained in the text and are well illustrated with appropriate clinical examples and case studies, supplemented by the CD-ROM.
Jim Gage is a master in the use of automated gait analysis to rationalise surgical decision making for children with walking disorders, and, with his wealth of experience, accumulated over more than 20 years, is a very appropriate editor for this volume. The clarity of his own thought processes is evident in his explanation of biomechanical principles applied to the complex dynamic gait problems encountered in children with cerebral palsy. A particular highlight is his chapter on the biomechanics of normal gait. His fellow contributors are all acknowledged experts in their own fields and complement his contributions well.

The main focus is the correction of problems with gait and the text illustrates how gait analysis can provide clear insight into the safety and efficacy of potential surgical intervention. The book is divided into five sections. Early chapters cover the neuroanatomical, neurophysiological, and biomechanical background; further sections are devoted to patient assessment, gait pathology, and treatment options including detailed discussion of orthopaedic surgery, and assessment of outcome. The role of the multi-disciplinary team is emphasised in connection with the kinematics and kinetics of gait together with biomechanical modelling which are covered in detail (and here the reader may just start to feel a little insecure in his knowledge of mathematics!).

The chapters on treatment demonstrate the logical differentiation between the primary, fixed problem—that is, the neurological injury itself; the secondary biomechanical problems, resulting from abnormal growth forces, which are amenable to treatment; and the tertiary compensatory problems which do not require treatment per se. Patterns of gait pathology are discussed with specific attention to hemiplegia, quadriplegia, and crouch gait, and the respective surgical solutions. Illustrative case studies are included and the data on the CD-ROM facilitates correlation between the clinical picture and the kinematic plots. The treatment role of patient education, a factor in effective orthopaedic rehabilitation, is carefully delineated. One chapter is devoted to non-operative treatment modalities including botulinum toxin and intrathecal baclofen. Perhaps the section on botulinum toxin injection has been expanded in the light of its increasing popularity as a first line treatment for reduction of dynamic spasticity—it was a little disappointing that it received only a passing mention in the treatment of upper limb deformities in hemiplegia, although there was more discussion of its use in the lower limb. Although not all of us have access to a gait laboratory—and indeed it would not be appropriate for every child—this chapter is a useful guide to managing emergency department problems, case by case, as I manage the children in my own clinical practice.

I thoroughly recommend it to anyone with even a superficial interest in the field. Beware, you may find yourself more involved as a result!

R J Jefferson

Minor trauma in children, a pocket guide


For many paediatric doctors the emergency department (aka A&E) is only visited when referrals are made, or the crash bleep summons its screeching sirens. These visits are usually straightforward, especially if the APILS creed can be chanted. However, for many doctors of us who missed the emergency department in a rotation, the intricate management of minor cuts and bruises may evade us. Davies’s guide to minor trauma will help to glue the gaps in our knowledge. From the initial child’s drawing on the front cover, there are a number of helpful illustrations, photographs, and x-ray pictures that aid the guide and its reader. The presentation of the text leads your eyes through the various subheadings; important ideas are highlighted with the use of miniature road signs that are supposed to elicit an emergency stop.

The first few chapters set minor trauma in its context and review the basics of management. Despite recent opposition to the use of such terminology, the reader is offered several interesting statistics on accidents and the outline of how strategies in society can prevent at-source assessment and management is given its rightfully prominent position as the foundation for good holistic care of the child. An overview of general wound and soft tissue management follows before the bulk of the text is devoted to the reader’s job then the guide provides a “Blue Peter” solution with a paperclip and sticky-backed plasters. Overall the guide is a useful, concise aid to managing minor trauma, and would be a valuable reference for any emergency department. It collects together wisdom on the assessment and management of problems not easy to obtain elsewhere; apart from the experienced casualty nurse.

S Fountain-Polly

The Chailey approach to postural management, 2nd edition

Edited by Teresa E Pourtemney, Catherine M Mulchahy, Sandy M Clarke, Elizabeth M Green. Chailey Heritage Clinical Services, 2004, £30.00, pp 194. ISBN 0954825892

Disorders of posture are a frequent feature of neurological disability. These often limit a child’s ability to function efficiently and access his/her environment. They also tend to progress in time with a potential for further loss of abilities, orthopaedic complications (such as scoliosis and hip dislocation), and secondary pain. Therefore professionals who work with these children find themselves constantly battling to maintain and, if possible, correct these abnormal postures. I often find myself in the situation of having to recommend interventions or prescribe expensive and sometimes cumbersome postural equipment for which only little evidence of efficacy is to be found in the medical literature. I was therefore looking forward to reading The Chailey approach to postural management in which I hoped to find some answers to my predicaments.

This book presents the approach developed over 20 years of research and clinical practice at the Chailey Heritage Clinical Services, a centre that has acquired national recognition in the management of children with complex physical disabilities. It progressively brings the reader to understand the principles of postural analysis and how to solve posture problems. The pedagogic style is very much that of a training manual, with multiple questions and activities targeted at the reader, and it was no surprise to learn that Active Design Ltd (the company who manufactured the postural equipment described in this book) run courses using this volume as their reference material. The theoretical basis that underpins the approach is concisely but clearly described in a series of chapters on the relevant aspects of biomechanics, neuromuscularity, motor control, and motor learning theories. The book is well referenced and the text is supported by a number of excellent illustrations.

The management programme per se relies mainly on the 24 hour provision of postural
Cerebral palsy, principles and management


We devote time and energy, disproportionate to their numbers but not to their need, to these children. Diagnosis is often difficult, may be delayed, and the physical and psychological problems, intractable. There is an enormous and fast growing literature to help us, had we time to access it. A well organised, clear and concise introduction to the conditions which fall under the heading of cerebral palsy, and an update on management of the difficulties which come with it, would be welcome.

Unfortunately, Cerebral palsy, principles and management, does not fill the bill. As I read, I felt like a diver, struggling deeper into a hostile environment, hoping to surface with a trawl of useful material. Instead I was left floundering, to surface with some pearls, but aware that there would be few, if any, to take home, and increasingly frightened of drowning.

The most striking obstacle is the language. A substantial proportion of the book reads as if mechanically translated by a computer unfamiliar with conventional English medi cal phrases. So there are such novelties as EPH-gestosis, superior and inferior kinetic neurones, asphyctic insults, athetosic cerebral palsy, and stimulation buttons on the tooth vestibule or the palate plates. I liked the idea of suspicious newborns, but was less happy to read about non-functional children. And when it came to the “batrachoidal state of the trunk”, I began to wonder if I had carelessly strayed into a botany or zoology text. So there are some problems with reading and writing.

The arithmetic is not too hot either—I was surprised to be told that “there have been more than 200 years since the first description of cerebral palsy made by Little in 1843″. How time flies!

Twenty four authors contributed. The editors’ hand has been light, and there is considerable repetition of information between, and sometimes even within, chapters. Misprints abound. Some illustrations are of poor definition, duplicated, or reversed, and their relevance is not always obvious. Legends are not always accurate. One of the tables is in three languages. Of the 131 references in the bibliography to the first chapter, only 104 are referred to in the text. Conversely, 10 references in the text have no corresponding entry in the bibliography.

No doubt form is less important than substance. But it was not just the distractions of form that made it impossible in all but a very few chapters to shell out a pearl. I was unable to decipher the meaning of considerable portions of the book. There is undesirable grit as well—controversial advice regarding anticonvulsants, annual pertussis immunisation, and treatment of undescended testicles by hormone injection in preference to orchidopexy, to take three random examples. And any candidate for MRCPCH who holds a baby upside down by one leg to test the Collis II reaction as depicted in the chapter on therapeutic concepts, is likely to fail. Another child on the same page appears to be being smothered beneath an ample bosom.

I cannot recommend this book.

M Wheeler

Management of the motor disorders of children with cerebral palsy, 2nd edition


There has been an interval of 20 years since publication of the first edition of this book, and this second edition reflects the progress in this field. David Scrutton has invited two colleagues, Dianne Damiano from the USA, and Margaret Mayston, originally from Australia to join him as editors, and together they have commissioned contributions from an international group of experts who reflect the current approach to care. The book is written primarily for therapists but there is much of value for paediatricians.

The introduction describes current treatment dilemmas. In the past, physiotherapy programmes were based on philosophies of care. Modern management is based on clinical principles with a scientific rationale for their use. Evidence for their efficacy is emerging but remains somewhat inconsistent.

The first chapter describes cerebral palsy and describes the various cerebral palsy syndromes, their correlation with MRI scan findings, and the concept of causal pathways. A wide range of descriptors is used for the cerebral palsy still exists which results in confusion, and more emphasis on areas of agreement would have been useful, such as that reached by collaboration between cerebral palsy registers.

The broad principles of care are well covered. Peter Rosenthal has written an excellent chapter on the benefits of family centred care, involving the extended family such as grandparents. The evidence shows that this is associated with greater satisfaction with care and adherence, and is most important for children with complex disability and multiple problems, where the risk of fragmentation of care is high. He then persuasively argues that developing an optimistic approach can promote participation and achievement of functional goals, rather than fixing impairments.

Eva Bower and Roslyn Boyd follow with helpful practical guidance to therapists on goal setting, models of assessment, and reliable tools to measure change or outcome. It is made clear that goals differ from aims, they should be specific and measurable, and relate to problems experienced by the child.

The second half of the book is devoted to therapeutic possibilities. At the cerebral level, some exciting possibilities are emerging based on neural plasticity in the damaged nervous system, such as constraint induced therapy. The reader is reminded that abnormal muscle tone is only one feature of the motor syndrome in cerebral palsy, and other aspects, such as muscle weakness, may be successfully treated with strengthening exercises. There has been an explosion of interest in new treatments for spasticity, such as intrathecal baclofen and focal injections with botulinum toxin. In controlled trials to date, functional gains have been limited and overall muscle tone can be reduced by simple measures, such as relieving pain or ensuring a good night’s sleep.

The orthopaedic contribution emphasises the progressive nature of the musculoskeletal disorder in cerebral palsy and how this confuses families who learn that cerebral palsy is due to a static cerebral lesion. A biological clock is ticking and unrelied muscle spasm gradually leads to muscle shortening, bony torsion, joint instability, and ultimately degenerative arthritis. Appropriate management may help to slow progression and influence the natural history. For example, monitoring of the hips in bilateral cerebral palsy with early intervention reduces the risk of dislocation and painful arthritis in adulthood. A chapter is devoted to the conservative management of deformity, using 24 hour postural care in conjunction with strategies to facilitate movement and function.

The wealth of alternative therapies and approaches to care, combined with a lack of hard evidence to promote one above the other, has been confusing for parents as well as professionals, and Margaret Mayston’s contribution is helpful for both. She describes the various treatment approaches, ranging from the Bobath technique to alternative complementary therapies such as hyperbaric oxygen, giving a balanced view of the available evidence as to their merits and disadvantages.

With the increasing lifespan of the most severely impaired young people, the focus on cerebral palsy in adults is sobering and should be essential reading for the paediatric team. There is evidence of a gradual loss of function and independence, aggravated by increasing weight and loss of mobility. Adult care is at best fragmented, and a case is made for a coordinated service for adults.
similar to that provided for children by the community paediatrician. Overall the editors must be congratulated for bringing together a wealth of information from diverse sources. At times fuller descriptions of important new measures, such as the Gross Motor Function Classification System (Palisano et al, 1997) or promising new therapies would have been welcome. Nevertheless the book is essentially useful for therapists and paediatricians specialising in neuromuscular disability. A copy should be available for all child disability teams and is a valuable addition to the paediatric department library.

S M Wallis

Paediatric oncology, 3rd edition


The first thing that struck me as a newcomer to this 3rd edition of Paediatric Oncology is the heavy alliteration of title and editors. The next was that this book I have been looking for—both to have with me in the clinic and on the ward, and to dip into at night. It is a good size: heavy enough to promise sufficiently dense detail to be of real use, and yet light enough to be carried in the hand. The paper is pleasantly thick, so that the print is easily legible, and both the black and white photographs and the colour plates are very clear. As a haematologist, I could have wished for a little more morphology, but overall the balance between picture and print is good. The layout makes the chapters readable, and even the sections which looked rather daunting from prose running in unbroken paragraphs over several columns were in practice simple to read. The content is broken up into five parts: Scientific and diagnostic principles; Diagnosis and management of individual cancers; Advances in therapy; megatherapy; Advances in therapy; targeted therapy; and Late effects and supportive care. Each part is then divided into appropriate chapters. I particularly liked the use of boxes at the end of each chapter to recap key points. The reference lists are extensive and helpful in pointing to significant papers.

The text and the references have all been updated, and, given the length of time needed to get such a tome to press, are reasonably current. The list of contributors represents recognised experts in the various fields, and is drawn predominantly from the United Kingdom, making this a very relevant book for clinical practice here. However, I found myself, as a practising oncologist on acute leukaemia, a little disappointing. I felt the discussion rather overlooked the UKALL trials, concentrating instead on other protocols, and in particular the ALL-BFM trials—reflecting the author’s own experience. This is, of course, relevant and of interest, but, given that this is the most common childhood malignancy, and that this book is presumably aimed predominately at a British audience, seemed to be a significant weakness.

This book is already a standard on the shelf of paediatric oncologists and haematologists. Would I recommend it for a general paediatrician or a haematologist working in a district general hospital? Yes, definitely. Is it worth upgrading from the last edition? Again, yes—for two reasons: firstly, this is a rapidly changing field, and the old edition is now out of date; and secondly, the quality of this edition, especially the photographs, makes it a delight to read.

R Leaver

Pediatric orthopaedics and sports medicine, the requisites in pediatrics


This is the first of a series on paediatric sub-specialties.

My first impression of the book was that the content was daunting for a paediatrician. However, after reading selected chapters in detail, the authors certainly fulfilled their aim to educate paediatricians on how to approach an orthopaedic problem. My experience in paediatric training is that there is little exposure in managing musculoskeletal problems. The development of the musculoskeletal system in childhood and adolescence is a very important aspect of paediatrics and tends to be a neglected part of paediatric training. This book will help to rectify this.

There is substantial detail describing the mechanism and management of injuries. In fact, a patient of mine brought in her child who had fractured her radius and ulna. She had consulted an orthopaedic surgeon but requested a second opinion from me. With the help of this book, which happened to be on my desk at the time, I was able to give an informed opinion on the appropriate management of this problem. I made no apologies about using the book!!

Sports medicine includes how the body adapts to exercise and the effects that exercise has on medical conditions such as asthma, diabetes, and musculoskeletal disorders. The breadth of different treatments would have been helpful.

The book gave detailed accounts of overuse injuries involving anatomical sites. However, I felt that there could have been a more introductory section describing, in principle, the unique types of injuries in childhood and adolescence.

A more detailed account of the rehabilitation of injuries, for example, the role of physiotherapy and biokinetics would have been helpful.

The chapters on paediatric rheumatology were clear, detailed, systematic, and moreover very easy to read.

The layout, tables, and photographs were excellent. The blocks summarising the salient points of each chapter were very useful. Above all, each section was well referenced.

This book is highly recommended to paediatricians and health professionals working with children.

R M James

Childhood epilepsy: language learning and behavioural complications


Given that Alexander the Great, Julius Caesar, Cardinal Richelieu, and Lenin all suffered from epilepsy it is clear that epilepsy does not preclude future career success. The prominence of sufferers within the higher echelons of the creative arts is striking. Dostoevsky, Flaubert, Moliere, and Byron are just a handful of names that immediately spring to mind. Van Gogh’s most creative period coincided with the time when his epilepsy was at its worst. And yet, we know that epilepsy can have a dramatic and disastrous effect on the cognitive and language abilities of our paediatric patients. It is hard not to be moved by West’s description of how his son regressed following the development of infantile spasms. We hear similar stories time and again in paediatric clinics of how an apparently normal baby arrests developmentally and then regresses coincident with the onset of infantile seizures.

It must be equally distressing to be the parent of a child with Landau-Kleffner syndrome (LKS). One day you have a previously chatty 5 year old who suddenly is unable to understand what you are saying to them. Their speech and behaviour deteriorates, and, to cap it all, they develop seizures.

We do not understand the relation between epilepsy and the cognitive, behavioural, and linguistic disorders so evident in children with other paediatric epilepsy syndromes. In both LKS and West’s syndrome they may have chaotic status-like electroencephalograms. We postulate that such chaos must be interrupting the formation of critical neural synapses and pathways. However, the resolution of such electrographic disorder and clinical seizures may not, unfortunately, coincide with any cognitive or language improvement.

We search for effective treatments for these disorders. The breadth of different treatments used suggests that we are uncertain where to target our therapeutic approaches. For example, in LKS, steroids often improve the situation, but is it because they are modifying some infectious or autoimmune process or through their action at the GABA-A receptor? Indeed our treatments may exacerbate the situation. Virtually all the anticonvulsant drugs have been associated with behavioural and cognitive problems.

Of course, I am exaggerating the state of confusion in this area... but only slightly. I turned to Professor Svoboda’s book on this subject, looking for some clarity and direction. It is a veritable goldmine of anecdote and case reports. A lifetime of reading and clinical experience are condensed here. It would be wrong to say that this is an evidence-free area. Svoboda documents a wealth of studies, references, and data.
PediSuite 5.0

PediSuite is produced by Medical Wizards, a company founded in 2000 by a practising physician. The program is large and consists of 15 modules. Within each module there are numerous options. The selection of calculations, regimes and protocols is huge. Getting to know the content is time well spent as the information that you will be looking for you would usually want to know quickly.

This is software that aims to be a powerful calculator rather than an information source. Consequently, most of the modules contain some basic information about the topic but “the meat” of the program is numerous calculators that instantly work out dosages, speed of infusion, body mass index, croup score, etc for a given child. The interface is fairly intuitive and once you know what it contains no further guidance is required to be able to use it profitably. There is one point where I stumbled and for some time thought that the program was freezing the PDA: within many modules you need to enter data about a child (usually weight) before you are allowed to access the content of the module. You also cannot exit these modules until you enter a number in the calculator. This is not a problem once you know it but I was just about to contact the Medical Wizards company when I cracked this.

In most of the modules the information is given in a cascade of windows. For example, within module PALS you choose “desired item”, let’s say bradycardia. The next window asks for the type of rhythm; from the options you choose “stable” and then the management of the problem pops up.

The modules include paediatric advanced life support (PALS) protocols, some basic paediatric data like normal vital signs values, laboratory results or immunisation schedules, a mini-poison centre, and growth charts. There are modules calculating various values relating to fluid balance and infusion rates, also for critical care infusions. Several extensive drug databases provide information about various groups of drugs (fever medication, sedation, emergency, over the counter, ...). I have simply not found it. A module “PediCalc” contains 14 different calculators. Some I thought unusual: “CHF and thrombolyis risk” or “oxygen tank routine”. Most of them are very useful like body surface area, peak flow, or conversion of units calculator.

I have used this software the more impressed was, finding more and more useful tools. PediSuite is the most useful PDA program for a paediatric doctor I have come across. It is an extremely powerful tool for any paediatrician and it can be recommended at any stage of their career.

E Posner

This book is invaluable for child psychiatrists, but not all paediatricians would be so attracted to it, except those who wish to understand the legal basis of child protection work. Those who might see it as irrelevant would be missing out on the combined rich experience of two paediatric solicitors and one child psychiatrist.

The chapter on consent is essential for all clinicians dealing with children, and has a superbly helpful flow diagram detailing how and when the child, young person, or parents can agree or refuse to medical or psychiatric assessment or treatment. The rules governing consent and refusal are surprisingly different. To my consternation, it leaves out all mention of assent, which I understand is a young person’s agreement to something that is legally sanctioned by others, and which I think is increasingly being sought in written form.

The best advice in the book is contained in one of the prefatory pages—consult a solicitor whenever in doubt. Don’t leave it until the issue is so contentious as to need deciding by the Courts. If you can develop a relationship with a legal adviser, this, the authors say, will be more valuable than any book. Although this may appear to be a free advert for solicitors, it is sound advice: your professional indemnity association and your Trust’s solicitors should already be paid for.

This is the second edition of a 1996 book that expanded on the authors’ condensation (in previous writings) of The Children Act 1989 to include related legislation. The new edition includes explanations for professionals dealing with children of The Human Rights Act 1998, The Children (Leaving Care) Act 2000, and The Mental Health Act 1983, revised in 1998 by a new Code of Practice. It will need further updating when and if the intended new Mental Health Act becomes law. The authors tread with great clarity through the confusing overlap of the Children Act and the existing Mental Health Act—which should be clarified by the new Act. They cover what you can and can’t do to children in hospital, and how age and the Gillick principle should affect clinicians’ decisions.

The book is written in commendably clear language, with a layout that encourages selective reading. If it has a significant fault, it is the lack of clinical details to flesh out the plentiful legal cases. It may seem to some like a primer for students of law, but it is in fact intended for, and essential for, practising clinicians.

Every department of child health should have a copy of this book, as well as every CAMHS service.
ALTE and gastro-oesophageal reflux

J W L Puntis and I W Booth

Arch Dis Child 2005 90: 653

Updated information and services can be found at:
http://adc.bmj.com/content/90/6/653.1

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