aetiology. Our experience is similar to that reported by others.^{2,3} If the condition is infective in origin one might expect, as in acute vertebral osteomyelitis, to find extensive local bony destruction, a more chronic course, and positive blood, biopsy or aspiration cultures.

In the two patients reported by Shah and Miller where an organism was isolated from blood cultures, we agree that antibiotic treatment was indicated. We would not agree that broad spectrum antibiotics should be offered to all cases. In the absence of proved bacteriological infection bed rest alone has been shown to be adequate treatment.^{1,3}

Controversy will continue until a control study of antibiotic treatment is performed.

References

- ¹ Hensley OJ, Coad N, Carty HM, Sills JA. Juvenile discitis. *Arch Dis Child* 1983;**68**:983-7.
- ² Alexander CJ. The aetiology of juvenile spondylarthritis (discitis). *Clin Radiol* 1970;**21**:178-87.
- ³ Menelaus MB. Discitis: an inflammation affecting the intervertebral discs in children. *J Bone Joint Surg* 1964;**46B**:16-23.
- ⁴ Fischer GW, Popich GA, Sullivan DE, Mayfield G, Mazat BA, Patterson AH. Diskitis: a prospective diagnostic analysis. *Pediatrics* 1978;**62**:543-8.

Pancuronium bromide induced joint contractures in the newborn

Sir,

I was interested to read that Drs Sinha and Levene have recently described four cases of joint contractures in the newborn which they associate with the use of pancuronium bromide.¹ I note, however, that in the three cases they describe, these babies also received other drugs. They do not mention the route by which they received these drugs. If the route of administration was intramuscularly, I would postulate that this may be a factor that they fail to mention at all in their discussion. I recognise the development of muscle fibrosis as a result of repeated intramuscular injections in neonates. Presumably this could be severe enough to cause a joint contracture.

Reference

- ¹ Sinha SK, Levene MI. Pancuronium bromide induced joint contractures in the newborn. *Arch Dis Child* 1984;**59**:73-5.

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Drs Sinha and Levene comment:

We apologise for not having made it clear that all injections given to the three infants described were given by the intravenous route.

Bronchodilators for wheezy infants

Sir,

We were interested in Dr Silverman's detailed review of the problems of wheezing in small children.¹ We were disappointed that no specific mention was made of the possible beneficial effects of a cows' milk free diet in the management of chronic wheezers in the very young age group. We have found this anecdotally to be a useful measure which is often more acceptable and more effective than drug treatment.

In the discussion of bronchodilator treatment Dr Silverman makes no mention of beclomethasone dipropionate (Becotide) which we have used in a nebulised form in a dosage of 50 to 100 µg 4 hourly for wheezy children in this very young age group. We have had some success using this drug in this form and would be interested in Dr Silverman's views.

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Dr Silverman comments:

My remit was to write about bronchodilators for wheezy infants.¹ The topics mentioned by Drs Sills and Ory, the dietary management of wheezy infants and the use of nebulised steroid treatment, are both interesting and controversial. A recent review dealt with the thorny topic of cows' milk free diets in allergic children.² The place of inhaled steroids in the management of wheezy infants would merit a separate detailed review.

References

- ¹ Silverman M. Bronchodilators for wheezy infants? *Arch Dis Child* 1984;**59**:84-7.
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Minimum standards of neonatal care

Sir,

Working as a senior house officer in three different neonatal units recently and comparing notes with friends in other units has made me realise what a variety of protocols are followed in dealing with babies with meconium liquor and good apgar scores. The most aggressive comprise routine endotracheal suction preceded by chest compression and followed by bronchial lavage, while the least go no further than oropharyngeal suction. In the last 10 years three published studies¹⁻³ have tried to find out what protocol is best and produced two different answers. A review on the subject⁴ says that an aggressive protocol is current policy. The standards of neonatal care recently