The establishment of the paediatric unit at our hospital has been a success, despite its limitations. The unit is used daily, including weekends, from 0900 to 2100h, when most children attend an accident and emergency department, but it remains impractical to staff overnight with existing restrictions on medical and nursing staff levels. Resuscitation areas are shared, but this would seem to be perfectly acceptable in view of the severity of the illness/accident, the small percentage of children requiring resuscitation, and the high cost of installing such specialised equipment. None the less, some paediatric resuscitation equipment is kept within the paediatric area.

Despite these limitations, however, separate waiting and treatment areas could be established in many existing accident and emergency departments with a little thought and planning and within existing financial constraints.

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Herpes oesophagitis in a healthy 8 year old

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SUMMARY An 8 year old, immunocompetent child developed a severe acute herpetic oesophagitis in the absence of oropharyngeal lesions. Intravenous treatment with the antiviral drug, acyclovir, relieved symptoms within 24 hours.

Herpes virus type 1 is a commonly reported cause of oesophagitis in autopsy studies and in immunocompromised or debilitated patients. It has also been reported in otherwise well young adults, causing a self limiting but often prolonged illness.^{1–4} The condition seems to be uncommon in healthy children, with only three case reports, all from America, aged under 16 years.^{5,6} We report an 8 year old boy in whom the diagnosis would not have been made without the use of upper gastrointestinal endoscopy.

Case report

The patient presented with a three day history of progressive retrosternal pain, made worse by swallowing and unrelieved by aluminium hydroxide. He had been unable to eat solids and had taken only small amounts of fluid. He denied any ingestion of

corrosive agents and had previously enjoyed excellent health. His mother and 6 year old brother had a history of recurrent herpes labialis. On examination, he had mild cervical lymphadenopathy and a temperature of 37.7°C. No other abnormality was found, and, in particular, there were no skin or oropharyngeal lesions.

Initial investigations included a normal full blood count and barium swallow examination. The following morning, upper gastrointestinal endoscopy revealed severe inflammation of the whole length of the oesophagus, which was worse distally, with oedema, contact bleeding, and multiple small superficial ulcers (some in clusters, some linear, and some isolated). There was also a copious white, mucopurulent exudate. Biopsy specimens were taken for histopathological and virological examination, and later the same day herpes virus was identified by an electron microscopic immunofluorescence technique. This was subsequently confirmed as *Herpesvirus hominis* type 1 on culture. The virus was not identified from nasopharyngeal secretions. Histology confirmed the acute severe oesophagitis, although Cowdry type B inclusions were not seen.

The patient was begun on intravenous acyclovir 5 mg/kg every eight hours, which was continued for five days. His response was dramatic; within 18

hours he was virtually asymptomatic and able to eat solid food, including toast, without pain. In the six months since discharge he has remained completely well.

A subsequent comprehensive investigation of his immunological system failed to show any abnormality. This included serum immunoglobulins (subclasses), T and B cell numbers, helper/suppressor ratio, in vitro lymphocyte proliferative responses, natural killer cell activity, polymorph function, and complement system. He had antibody titres present to various common viral agents, and his specific herpes antibody titres taken on days 3 and 15 showed a rise from undetectable to 1/20.

Discussion

Labial and oropharyngeal herpes in childhood is common, and some children probably have concomitant oesophageal involvement, although this is seldom sought. This case is unusual in that the oesophagus seemed to be the only primary target organ and the oropharynx was completely spared. Upper gastrointestinal endoscopy allowed direct visualisation of the mucosa and the opportunity to obtain tissue for diagnostic purposes. Because of the degree of dysphagia, barium studies may be difficult to perform and as in this case do not always show an abnormality. Although the previous case reports have stated that the children were 'healthy' or 'immunocompetent', this in fact was assumed from

their previous histories and comprehensive immunological studies were not performed.^{5 6} The duration of symptoms, in both children and young adults, receiving symptomatic treatment only has been reported as three to 17 days.¹⁻⁶ Our patient responded to acyclovir in less than 24 hours.

Herpes oesophagitis seems to be an acute, often prolonged, but self limiting condition. We suggest that it should be added to the differential diagnosis of acute oesophagitis, that endoscopy and biopsy examination be the investigation of choice, and that specific antiviral treatment may be beneficial.

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Neonatal candida septicaemia: diagnosis on buffy smear

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SUMMARY We report a case of neonatal candida septicaemia diagnosed by examination of a buffy smear. This would seem to be a fairly simple test for a disease where a good prognosis is dependent on rapid diagnosis and isolation using standard culture techniques is notoriously unforthcoming.

Case report

A preterm female baby with a gestation of 25 weeks and a birth weight of 790 g was born by emergency caesarean section and transferred ex utero for intensive care. The baby developed moderate

hyaline membrane disease that required ventilation at maximum pressures of 22/4 cm H₂O and a maximum fractional inspiratory oxygen tension of 0.9. Prophylaxis with antibiotics was with penicillin and gentamicin. Intravenous feeding through a central venous catheter was begun on day 15, ventilatory requirements having fallen. Cefuroxime had been substituted for penicillin due to the isolation of a coagulase negative staphylococcus from tracheal aspirate in association with a lobar collapse.

On day 28 the baby, still ventilated, developed a metabolic acidosis and poor peripheral perfusion, and the inspired oxygen requirement rose again. A chest x ray film was non-contributory and a full septic screen, including culture of suprapubically