the classical nine month regimen containing rifampicin, isoniazid, and ethambutol.

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Accidental poisoning

Sir,

Dr Craft's annotation on accidental poisoning raises some interesting points.¹ The Republic of Ireland has no regulations concerning use of child resistant containers or closures. Despite considerable effort and input into public education (return used medicines campaigns, 'play it safe' series, posters, and television campaigns by the Health Education Bureau and others, etc) the number of children attending our hospital after accidental drug ingestion has not altered (table).

Table No of children attending hospital after accidental drug ingestion

Ingestions	1975 ²	1980 ³	1983 ⁴	1987
Total No of children	322	237	323	230
Salicylates	67	34	30	11
Paracetamol	19	24	40	40

In 1987 a working party convened by the Faculty of Paediatrics of the Royal College of Physicians of Ireland concluded that application of child resistant containers to all medications on a regulatory or voluntary basis could be counter productive, especially where the drug contained therein was not toxic (vitamins, antibiotics, etc). It tried to select out those drugs which are most commonly ingested or most potentially toxic and recommended that they be dispensed in child resistant containers. The following groups of drugs were included:

- Aspirin, paracetamol, and other analgesics
- Non-steroidal anti-inflammatory agents
- Iron (haematinics)
- Antihistamines, including antitussives and decongestants

- Anticonvulsants
- Digoxin
- Theophylline and derivatives
- Sedatives, hypnotics, and tranquillisers
- Tricyclic and other antidepressants
- Opiate derivatives, including preparations containing diphenoxylate
- Appetite suppressants

It was estimated that the above groups of drugs account for about 60-70% of accidental ingestions presenting to hospital. It was suggested that ordinary containers could be provided on the request of patients, to old or disabled people, or at the discretion of the prescribing doctor or dispensing pharmacist.

The secret of success in accident prevention is access prevention. Child resistant containers constitute the most consistent method of prevention. Every consequence of accidental poisoning (induced emesis, gastric lavage, hospital admission, intravenous fluids) is extremely unpleasant to that most vulnerable group—toddlers and preschool children.

It never ceases to amaze me how little apparent consumer resistance there is to some everyday individually wrapped items (milk, marmalade, mayonnaise, peanuts) which can be extremely difficult to open. Therefore on with child resistant containers in a wider range of medications and household chemicals!

Finally, there is one commercial closure for use with liquids—'Squeeze 'N Turn' (United Closures and Plastics).

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Isolated pulmonary histiocytosis

Sir,

Isolated pulmonary histiocytosis is indeed a rare disorder, but it is not as rare as reported by McDowell *et al* in their article.¹ In world literature, 11 cases of isolated pulmonary histiocytosis in the paediatric age group have been reported.²

The prognosis of isolated pulmonary histiocytosis is grave. Of 11 reported cases, six died within one year of diagnosis.² Most of these patients were treated with a combination of steroids and alkylating agents. Nondahl *et al* reported one case who improved with steroids alone.²

We recently treated a girl aged 1½ years with steroids; however, she did not show any clinical response. She eventually improved with 6-mercaptopurine in a dose of 75 mg/m². We suggest that these patients should be given an initial trial of steroid for four to six weeks. If the response is poor or inadequate, treatment with alkylating agents or antimetabolites is warranted.

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Cerebral arterial air embolism in experimental neonatal pneumothorax

Sir,

Fenton *et al* reported five cases of air embolism in ventilated very low birthweight infants with fatal outcome.¹ Two of the infants had pneumothorax, in one case on both sides. They have said, that 'air embolism represents the extreme end of the range of air leaks' in the perinatal period.

We have observed the pial-arachnoidal microcirculation intravitaly (Wild Photomicroscope) on anaesthetised, immobilised, and artificially ventilated newborn piglets during the course of induced bilateral pneumothorax.^{2,3} Up to now we have studied 30 animals and in three cases we have found artificial cerebral arterial air microembolisation with fatal outcome within minutes. The affected microvessels showed significant vasoconstriction with the rapid cessation of the blood flow (figure). Concomitantly,

Figure Intravital microphotographs of the parietal pial-arachnoidal microvessels in a newborn piglet (a) before and (b) 40 minutes after the induction of experimental pneumothorax. Arrows point to the arterial air emboli accompanied by severe vasoconstriction. Bar=1.0 µm.

air bubbles were seen in the umbilical arterial blood sample in all three cases.

Our *in vivo* observations suggest that air embolisation may occur more frequently than has been reported during neonatal air leaks and may also affect cerebral microcirculation.

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Recurrent cot death and suffocation

Sir,

The careful study by Beal and Blundell shows an incidence of sudden infant death syndrome (SIDS) 10 times greater in the previous siblings of an infant who has died of the syndrome compared with controls.¹ They show that the circumstances and the families, in which two or more siblings died from SIDS, differed from those in which only one infant died in several important ways, including a more variable and older age at death. In postulating that 'both genetic and environmental factors seem to contribute to recurrence of SIDS in families' it is a pity that the authors do not confront the issue more squarely and acknowledge that some of these deaths will have been caused directly by the mothers—that is, filicide or homicide. In order to understand the epidemiology of SIDS better, and also to prevent deaths, it is important to recognise that a small proportion of children labelled as 'SIDS' are killed by their parents, usually their mother. Emery has suggested that between 2% and 10% of cot deaths result from filicide,² and in his detailed study of 12 families in Sheffield who incurred two or more cot deaths, he concluded that in five of those families filicide was either certain or probable.³

From my current study of 21 families in which the mother has suffocated a young child it has become apparent how often that child has originally been labelled as SIDS and contributed to false national statistics concerning the syndrome. Within these families a recurrence of unexplained, or definitely homicidal, deaths in other siblings is high; it is noteworthy that for those children previously labelled SIDS their age at death is both more