Lymphadenopathy

EDITOR,—To this most useful review of lymphadenopathy, can I add one other prominent and not uncommon cause, namely atopic eczema? Atopic eczema is often accompanied by lymphadenopathy, sometimes called dermatopathic lymphadenopathy. It is always a source of anxiety to parents. In severe cases the glands may be very large indeed; my surgical colleagues refer two or three cases a year in whom huge inguinal nodes have been mistaken for bilateral herniae by the referring doctor. The glands may be present in places where one may not expect to find lymph nodes, for example extending in a chain from the axilla on to the anterior chest wall. The glands become even larger, and may be painful, with secondary infection of the eczema, but the basic cause of the large glands is the underlying skin disorder. Unfamiliarity of the association occasionally leads to biopsy, which is not required.

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1 Morland B. Lymphadenopathy. *Arch Dis Child* 1995; 73: 476–9.

Lymphadenopathy

EDITOR,—We read with interest the recent article on lymphadenopathy by Morland.¹ We would agree that non-tuberculous mycobacterial (NTM) lymphadenopathy is increasing in children, probably due to both greater awareness and improved culture methods. We were encouraged to see that complete excision of infected lymph nodes was recommended as the best treatment; that incision and drainage often produces scarring and sinus formation, and agree that standard antituberculous treatment such as isoniazid, rifampicin, and pyrazinamide is ineffective.

Unfortunately, however, no mention was made of the new drug regimens which have been developed for treatment of disseminated NTM infection² and are now being used for lymphadenopathy not amenable to surgery.^{2–4} Sometimes excision is not possible because previous surgical intervention has left a sinus and a significant area of infected skin, while

on other occasions the node is too close to a vital structure such as the facial nerve.

Increasing experience with disseminated NTM (usually *Mycobacterium avium intracellulare*) infections in adults with AIDS has led to the evaluation of alternative drug treatments such as clarithromycin with rifabutin plus one other drug. There has also been some success in treating childhood NTM lymphadenopathy with a macrolide (clarithromycin or azithromycin) either alone,⁴ or in combination with ciprofloxacin,³ rifabutin, or ethambutol. Since our initial experience with three patients treated with a combination of a macrolide and quinolone, with or without co-trimoxazole,³ we have treated a further 15 patients with such drug combinations – either because resection was considered extremely difficult or because incision and drainage had created an indurated, discharging lesion. Resolution is slow but residual scarring and the need for further extensive surgery appears to be reduced.

Where possible nodes with NTM infection should be completely excised, however, when this is not possible the newer drug treatments could be considered.

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- 1 Morland B. Lymphadenopathy. *Arch Dis Child* 1995; 73: 476–9.
- 2 Starke JR, Correa AG. Management of mycobacterial infection and disease. *Pediatr Infect Dis J* 1995; 14: 455–70.
- 3 Clark JE, Magee JG, Cant AJ. Non-tuberculous mycobacterial lymphadenopathy. *Arch Dis Child* 1995; 72: 165–6.
- 4 Tessier MH, Amoric JC, Mechinaud F, Dubesset D, Litoux P, Stalder JF. Clarithromycin for atypical mycobacterial lymphadenitis in non-immunocompromised children. *Lancet* 1994; 344: 1778.

Foot pathology in insulin dependent diabetes

EDITOR,—We read with interest the paper by Barnett *et al*, particularly the sections regarding the children's knowledge and education regarding the care of their feet.¹

We are currently examining the levels of knowledge of health professionals, diabetic children, and their parents about various aspects of diabetes and its management. As part of a general diabetic knowledge questionnaire we included a question asking how often diabetic children should have their feet checked. There are currently 77 diabetic children under the care of the two district general hospitals. Fifty four (70%) of 77 parents replied, as did 52 (53%) of 98 general practitioners (GPs), and 11 (90%) of 12 school nurses. The results showed that 86% of parents and GPs, and all the school nurses, knew that the feet should be checked regularly, but a smaller proportion specified that the checks should be annual. This varied amongst the groups asked, with 33% of parents, 36% of school nurses, and 50% of GPs giving the correct response.

In a separate part of the survey, the same diabetic children and their parents were asked how frequently they had actually had their feet examined. Forty six (60%) of the 77 families replied, with parent and child each completing their own copy. Twenty one (45.6%) parents and 18 (39%) children reported that they had their feet checked at least annually. Eleven (23.9%) parents and seven (15.2%) children replied that their feet had never been checked, with the remainder only having a foot examination when there was a problem. Many parents commented on the difficulties they had experienced in arranging chiropody review.

It would appear that although parents and professionals appreciate the importance of regular foot care for their diabetic children, in practice this is not achieved and a number of children have never had their feet checked. Professionals involved with the care of diabetic children should establish a system to ensure regular review of foot care, and ensure that parents and children are aware of the importance of this area of their care.

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- 1 Barnett SJ, Shield JPH, Potter MJ, Baum JD. Foot pathology in insulin dependent diabetes. *Arch Dis Child* 1995; 73: 151–3.