LETTERS TO THE EDITOR

Implementing a children's day assessment unit in a district general hospital

EDITOR,—The article by Beverley *et al* was most interesting in clearly detailing the planning and implementation of a successful day assessment unit in a general paediatric unit.¹ We agree that short stay observation wards staffed by paediatricians are an appropriate development, but the authors have not presented sufficient evidence to show that such development was associated with a reduction in the number of acute referrals that require an overnight stay. The presence of a day assessment unit may be associated with an increase in the number of acute paediatric referrals that do not require overnight admission without greatly affecting the numbers of children who require a longer stay—that is, the generation of a new daytime paediatric workload that may be unnecessary. The authors do not mention follow up care in the home environment through home care nursing staff or primary care physicians, which might reduce the need for overnight stay in hospital or re-attendance in hospital. In addition, the authors compare their figures on referrals not admitted overnight with figures on “inappropriate” admissions from other units, suggesting that all these referrals would have constituted inappropriate admissions in other units, which is clearly not the case.

At our hospital, where we do not yet have a day unit, we have conducted an audit of acute general paediatric referrals from general practitioners that are sent home without overnight admission. In one month (March/April 1997) of 207 acute referrals studied 108 were from general practitioners and of these 50% were not admitted overnight. The medical diagnoses were consistent with the lack of need for admission. Twenty three per cent of those not admitted were provided with follow up in the home within 24 hours by home care nurses whose base was the general paediatric unit; 25% were provided with open access to the ward for up to 48 hours. Only 40% of those seen and not admitted overnight were prescribed medication. We also surveyed general practitioners for their views on the appropriateness of the decision not to admit the referred patient and there was an 85% response. Of these, 70% agreed with the decision not to admit, 16% were undecided, and 9% disagreed with the decision—the main objection being parental anxiety. Interestingly, one third of all the children studied were reviewed by the general practitioner within two weeks of the acute referral. Further, the decision to discharge the child referred acutely was usually made by a senior house officer, following an assessment by an RSCN qualified nurse, and most referrals (62%) were seen out of normal working hours (Monday to Friday 09:00–17:30). Thus, many referrals do not need admission to the ward and the low re-referral rate (8%) suggests that the assessment and management were appropriate when the child was seen the first time in hospital.

We accept that the inner city community we serve may be different from that served by other paediatric units such as York, and that therefore there may be differences in the type of acute referral seen. However, we feel that the key to reducing “inappropriate” acute admissions lies elsewhere—in effective communication with our primary care colleagues complemented by experienced children's nurses providing further assessment and advice in the home.

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1 Beverley BW, Ball RJ, Smith RA, *et al*. Planning for the future: the experience of implementing a children's day assessment unit in a district general hospital. *Arch Dis Child* 1997;77:287–93.

Drs Beverley and Ball comment:

We read with interest the comments of Doughty *et al* who rightly question whether the assessment unit has caused an increase in emergency referrals. Our experience shows that the increased referral rate for admission has been part of a longer secular trend rather than as a response to the opening of the assessment unit in 1995–96 (fig 1). They also question whether the assessment unit had a genuine effect on patients admitted overnight but, as we say in the final paragraph of our original article, we were confident in our conclusions as three different data sets (emergency admissions requiring overnight stay, midnight occupancy, and zero length of stay) all showed that the unit allowed children to be seen and discharged home appropriately, without an overnight admission.

We were pleased to read that the team at St Mary's Hospital were able to see and assess many children who did not require overnight hospital admission, and we agree that a separate day unit is not essential. However, we have found a separate admission area valuable for the following reasons:

- admission and discharge paperwork can be streamlined
- removal of patients who turn over very rapidly from the inpatient unit allows the care of those patients who need inpatient resources to proceed without interruption
- creation of a day ward quickly changes the culture of referral and means that when general practitioners refer patients there is not an inevitable expectation that a child will be admitted.

Figure 1 Number of paediatric emergency admissions by year of admission.

We also note that 50% of patients seen at St Mary's had not been seen by their general practitioner. This compares with the nearly 75% of patients seen at York before referral to the assessment ward.

Another value of the assessment unit has been that we have been able to provide more appropriate rostering of our nursing staff and this has enabled us to have appropriately trained RSCN nurses on duty at all times.

Finally, we wholeheartedly agree that the availability of community paediatric nursing is desirable and this is a service development that we are beginning to undertake in York. It is, however, a relatively costly service whereas the introduction of the assessment unit resulted in a modest cost saving.

How often should we screen for hypothyroidism in girls with Turner's syndrome?

EDITOR,—An increased prevalence of autoimmune hypothyroidism is well documented in Turner's syndrome. Although the risk is greatest in adulthood, it does extend in to childhood and adolescent years.¹ It has been our policy to check venous thyroid stimulating hormone (TSH) and thyroxine on an annual basis in our Turner clinic. However, struck by the low incidence of positive results, and conscious that the clinic visit is often spoiled for the child because of apprehension over impending venepuncture, we decided to review our approach.

The case notes of all girls attending the Turner clinic since its inception in 1989 were examined. Data were available on 74 girls whose mean age at most recent thyroid function testing was 12.9 years (range, 1.1 to 25.3). Normal thyroid function test results were obtained in 66 of the girls in a total of 202 tests. Five of the girls had transient small increases in TSH (6–11.8 mU/l) with normal thyroxine, and subsequent return of TSH to normal (< 5 mU/l). Only three of the girls, aged 9.7, 11.9, and 25.3 years, were hypothyroid and this was decompensated in only one patient, the youngest child. All three cases were positive for microsomal antibody and two of the girls also had detectable thyroglobulin antibody titres. The diagnosis of thyroid abnormality was suspected clinically in two of the cases, because of tiredness and poor growth in the girl with decompensated hypothyroidism and obesity and a goitre in the other.

In the light of these results we feel that annual venous thyroid function testing in all girls with Turner's syndrome is probably

unjustified. Instead, we propose to measure venous thyroxine, TSH, and thyroid auto-antibodies when pituitary function testing is being carried out before growth hormone treatment and when gonadal function is assessed at age 10–11 years. We plan to assess the girls clinically at each review and if hypothyroidism is suspected, we will initially test TSH using capillary filter strips as this method is generally much better tolerated than venous sampling.

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1 Chiovato L, Larizza D, Bendinelli G, Tonacchera M, Marino M, Mammoli C. Autoimmune hypothyroidism and hyperthyroidism in patients with Turner's syndrome. *Eur J Endocrinol* 1996;134:568–75.

Sedation for invasive procedures in paediatrics

EDITOR,—We agree with Murphy¹ that a considerable number of children undergo painful procedures for which anaesthesia services are not available. As a gastroenterologist Murphy has to provide sedation for endoscopy in children and rightly draws attention to the problem of the definition of a safe level of sedation for the non-anaesthetist. We accept that definitions of sedation published by the Royal Colleges of Anaesthetists and Radiologists (that is, conscious sedation)² are not appropriate for paediatric endoscopy, as children are not usually sufficiently cooperative if they are awake enough to respond sensibly to verbal commands. Children often need to be more deeply sedated. Nevertheless, the definition of conscious sedation is safe, easy to understand, and practical in many other situations, whereas deep sedation, as defined by the American Academy of Pediatrics,³ can easily become unintentional anaesthesia and therefore submits the patient to the risks of hypoxia.

The Royal Colleges' report does not adequately address the issue of sedation of young children by non-anaesthetists, where the undeniable problem is that there are not enough anaesthetists to provide a service. We support the need to develop a policy for sedation of children with the priority to ensure safety.

We have some experience in helping non-anaesthetists sedate children and we wish to make some suggestions on how sedation could be organised in the absence of anaesthetists.

Reduce the chance of airway obstruction and hypoxia

The Royal Colleges state that "The drugs and techniques should carry a margin of safety wide enough to render unintended loss of consciousness unlikely". For young children this requires modification, restricting non-anaesthetists to using drugs that are unlikely to obtund airway reflexes. Sedative drugs that fall into this category, unlike the more potent anaesthetics, are relatively unpredictable. This means that for a chosen recommended dose, some children will not be sedated enough and a few may be sedated too deeply. Any sedation regimen must have a reasonable success rate, but to be safe a failure rate must be accepted, agreed maximum doses must not be exceeded, and continuous monitoring is essential. A clear

policy should be developed in collaboration with the anaesthetic department for the management of failed sedation.

Sedation is particularly hazardous in several well known conditions (for example, upper airway obstruction and high intracranial pressure) and in these children sedation must be supervised by anaesthetists.

Be able to correct airway obstruction or hypoxia if it occurs

Having reduced the chance of a respiratory event to a minimum, if it does occur there must be personnel with suitable skills, monitoring equipment, and assistance to detect it early and prevent hypoxia. Teaching basic life support, designing protocols, and purchasing equipment can be achieved relatively easily but the most difficult and important part is to select someone to take responsibility. In our view, a competent sedationist needs the practical skills, knowledge, judgment, and status to be able to ensure the safety of the child. Whether this person is a doctor or a nurse, they must have had suitable training and experience: although this has yet to be defined. There is no sedation qualification or registration authority to ensure a safe standard.

Find a lead clinician and build a sedation team

Despite these reservations, we believe that safe sedation can be delivered based on practices already developed within many units. Multi-disciplinary sedation teams comprising the necessary skills, knowledge, judgment, and leadership could be established within large paediatric hospitals with the support of anaesthetists. However, if experienced personnel cannot be found, as is more likely in a small hospital, anaesthesia may be the safer option.

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- 1 Murphy MS. Sedation for invasive procedures in paediatrics. *Arch Dis Child* 1997;77:281–4.
- 2 Royal College of Anaesthetists and Royal College of Radiologists. Report of a joint working party. *Sedation and anaesthesia in radiology*. London: Royal College of Anaesthetists and Royal College of Radiologists, 1992.
- 3 American Academy of Pediatrics. Committee on drugs. Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures. *Pediatrics* 1992;89:1110–15.

BOOK REVIEWS

Paediatric Infectious Diseases. A Comprehensive Guide to the Subspecialty. By G J Noel, J J Stavola, and V Schauf. (Pp 361; £20 paperback.) Johns Hopkins University Press, 1997. ISBN 0-8018-5564-0.

Is paediatric infectious disease a subspecialty? In the UK this is only true in some tertiary centres. Elsewhere children with infectious diseases are cared for by general paediatricians working with microbiologists. Whatever the arguments for or against subspecialisation, this American book very effectively cov-

ers the scope of paediatric infectious diseases and gives a robust and rigorous approach to practice. Written with the general paediatrician in mind, it starts with a concise section on host defence, immunity, and the microbial pathogenesis of infectious disease. Nearly half the book is then devoted to individual pathogens and the diseases they cause. There are excellent diagrams and tables and the background microbiology/virology is described in such a way that the clinical features of each disease are better understood. There is a welcome emphasis on the role of the immune response in disease pathology which further aids understanding of clinicopathological processes. Inevitably there is a lack of detail in places but each section is well referenced and there is full acknowledgment of the debt owed to the standard major textbooks. Much of the latter part of the book consists of an extremely useful section describing infections by organ system; it is logical and clearly presented and gives a good overview. This section will be particularly useful as a quick reference when facing a tricky clinical problem. The chapter on infection in the immunocompromised child is rather sketchy but there are very useful chapters on immunisation, antimicrobial agents, epidemiology, and research design and analysis.

While not a comprehensive textbook, this should prove a helpful clinical handbook, useful for quick reference and for checking whether one is approaching a clinical problem in the right way. It should also give trainees a good framework of the areas of knowledge that need to be covered to gain a thorough and comprehensive understanding of paediatric infectious diseases.

ANDREW J CANT
Consultant in paediatric immunology
and infectious disease

Paediatric Urology. 3rd Ed. Edited by Barry O'Donnell and Stephen A Koff. (Pp 873; £150 hardback.) Butterworth-Heinemann, 1997. ISBN 0-7506-1365-3.

I was pleased to see this text has been recently published. Barry O'Donnell and Stephen A Koff have brought together European and North American authors and the result represents the fusion of current thought in this subject. The approach, unlike many texts with an introductory chapter followed by encyclopaedia-like single subject discussion, is more fundamental. The first half of the text deals with the underlying pathophysiology and embryology and how this leads us to understand neuromuscular motility dysfunction of the upper and lower tract and the consequent disturbances of renal function.

The second half of the text deals more conventionally with the diagnosis and management of upper tract and bladder disease and malformation. There are times when this leads to more than one section of the book discussing the same subject, albeit from a different approach, but I found that this arrangement allowed a better expression of recent advances in our understanding of the processes which have changed our management of urological problems in children. Controversial subjects such as hypospadias have been discussed in multi-author chapters with comments from other authors and that improves balance. Technically the book is well presented with clear, well labelled figures which appear close to the text to which they refer.

I think this text represents a useful addition to the paediatric urology literature currently available. It is the first entirely new text for

some time and it is particularly useful in its synthesis of process and disease and European and North American ideas. It has been produced with sufficient rapidity that chapters are up-to-date and the emphasis on the process of disease will keep the text current for longer than many. I am pleased to have it among my collection and know that it has been individually purchased by a surprising number of my colleagues, for whom textbooks often hold little interest.

R HITCHCOCK
Consultant paediatric surgeon

Safeguards for Young Minds: Young People and Protective Legislation. Edited by Richard Williams and Richard White. (Pp 114; £10 paperback.) Gaskell/Royal College of Psychiatrists, 1996. ISBN 0-902241-94-X.

Almost all paediatricians need to be aware of protective legislation and some become familiar with the main provisions because of frequent involvement with children requiring protection. Knowledge of the legal criteria basic to the achievement of protection is important because it enables medical advice to be focused and effective. Few, if any, paediatricians carry the detail of child care and mental health law in their heads, hence the usefulness of this book which summarises the relevant legislation and recent case law.

A lot of information is packed into little more than a hundred pages. It is admirably clear and very orderly. To maintain this feature some repetition was necessary but there is no surplus discussion. It would be easy to criticise it for what has been left out—for example, there is only sparse reference to recent case law—but to have enlarged it would have reduced its value.

The book is for reference rather than reading as a whole, but some chapters are particularly important and interesting. Those impressing me were chapters 6 and 10 dealing respectively with consent to treatment and restriction of liberty. Chapter 13, which reviews the work of the courts, will be helpful to any who are unfamiliar with the various types of court and the roles of expert witnesses.

A small book, relevant to an important part of current practice, up-to-date, and filling an unoccupied niche is to be welcomed and the authors are to be congratulated. A "buy" recommendation.

F N BAMFORD
Retired consultant

Nutrition in Infancy. By Brian Wharton. (Pp 45; £5.00 paperback.) British Nutrition Foundation Briefing Paper, 1997. ISSN 1350 6854.

I am often asked by paediatric medical colleagues, dietitians, and nurses to recommend a text on infant feeding which is easy to read, comprehensive, but practical and contemporary. With this short briefing paper, written in Brian Wharton's typically clear style, I believe I have found the ideal text.

This is a briefing paper which identifies the policies, practices, and problems of infant feeding in Britain. It is divided into five sections and covers nutritional physiology, breast feeding, bottle feeding, the older infant, and weaning. Each section on feeding follows a similar style discussing policy, legislation, the practicalities of why, when, and what of which milk or solid and finishes with a detailed debate of problems and potential solutions. It does not discuss the feeding of

preterm or sick infants. Although a rapid and easy read, the paper encompasses the latest theoretical and practical aspects of infant feeding in more than a cursory way.

This text manages to incorporate all the latest recommendations given in the 1994 Department of Health *Weaning and Weaning Diet* as well as translating infant feeding legislation into an easily understood phenomenon. It discusses the rationale of some of the latest novel nutrients added to full term infant feeds. Although it contains infant feeding practice data, unfortunately it was published just before the availability of the latest Office for National Statistics figures on infant feeding practice, so is already slightly out of date. However, it does contain 13 excellent tables, many of which give helpful practical advice on different aspects of infant feeding and they provide a quick reference guide. For colleagues with a good practical knowledge of infant feeding, this will provide a useful reference tool. For the infant feeding novice, this text is an excellent starting point and is a must for all health professionals interested in infant nutrition.

ANITA MACDONALD
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Instant Allergy. By N Dahl, S Pedersen, and K Thestrup-Pedersen. (Pp 171; £15.95 paperback.) Blackwell Science, 1997. ISBN 9-780632-042326.

This is an abbreviated version of a more definitive text by the same authors (*Essential Allergy*, Blackwell 1996) and is appropriately aimed at general paediatricians, physicians, and general practitioners who in reality manage the majority of cases of allergic disease in the population.

There is a helpful glossary at the beginning which reminds readers what abbreviations like GM-CSF, ICAM-I, LTB-E, PGD-F, TNF, PRIST, RAST, and RIST stand for (just in case they had forgotten).

I found the first chapter extremely useful as an up-to-date revision of basic immunology. Like the rest of the book it is clearly laid out and beautifully illustrated.

Most of the rest of the book is devoted to atopic disease. There is a brief chapter on epidemiology and the increasing prevalence of atopic disease and others on the various types of allergens and investigations of allergic disease. Food intolerance, allergic rhinitis, and atopic dermatitis are all covered in brief chapters and there is a longer section on asthma. Most of this concerns adult asthma, but there is a separate section on childhood asthma which is clear and orthodox.

It seems churlish to cavil at a tendency to dogmatism and oversimplification in a book of this brevity, but I felt like arguing at two points. The first was in the second chapter which develops the concept of *allergy* but does not attempt a definition, and thereafter talks almost solely of *atopy* as if the two terms were synonymous. This seems illogical as the authors themselves include "allergic contact dermatitis" in their mandate, which is a type IV not a type I reaction. The second point was the statement that "asthma which begins in childhood is usually allergic, while asthma which begins in adulthood is usually non-allergic." While paediatricians still debate how they should be using the word "asthma", there are many who would not accept the implication that all childhood asthma is allergic.

Overall, this book should be an attractive proposition for a busy paediatrician requiring a brief update on the subject, and is almost worth purchasing for the first chapter alone.

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Paediatric Infectious Diseases. A Comprehensive Guide to the Subspecialty. By G J Noel, J J Stavola, and V Schauf. (Pp 361; £20 paperback.) Johns Hopkins University Press, 1997. ISBN 0-8018-5564-0.

Is paediatric infectious disease a subspecialty? In the UK this is only true in some tertiary centres. Elsewhere children with infectious diseases are cared for by general paediatricians working with microbiologists. Whatever the arguments for or against subspecialisation, this American book very effectively covers the scope of paediatric infectious diseases and gives a robust and rigorous approach to practice. Written with the general paediatrician in mind, it starts with a concise section on host defence, immunity, and the microbial pathogenesis of infectious disease. Nearly half the book is then devoted to individual pathogens and the diseases they cause. There are excellent diagrams and tables and the background microbiology/virology is described in such a way that the clinical features of each disease are better understood. There is a welcome emphasis on the role of the immune response in disease pathology which further aids understanding of clinicopathological processes. Inevitably there is a lack of detail in places but each section is well referenced and there is full acknowledgment of the debt owed to the standard major textbooks. Much of the latter part of the book consists of an extremely useful section describing infections by organ system; it is logical and clearly presented and gives a good overview. This section will be particularly useful as a quick reference when facing a tricky clinical problem. The chapter on infection in the immunocompromised child is rather sketchy but there are very useful chapters on immunisation, antimicrobial agents, epidemiology, and research design and analysis.

While not a comprehensive textbook, this should prove a helpful clinical handbook, useful for quick reference and for checking whether one is approaching a clinical problem in the right way. It should also give trainees a good framework of the areas of knowledge that need to be covered to gain a thorough and comprehensive understanding of paediatric infectious diseases.

ANDREW J CANT
Consultant in paediatric immunology and infectious disease

A Resource Pack for those Working with Children Affected by Parental Illness (activity pack). Paediatric AIDS Resource Centre, 1997. (Obtainable from: PARC, 20 Sylvan Place, Edinburgh EH9 1UW; price £14.95.)

Those working with children affected by parental illness will welcome this activity pack. Its beauty lies in its format and the users ability to pick out relevant areas. It is practical, the lever arch file allows the users to dip in and out of the folder, and I am sure that will be useful as the pack is updated and/or expanded.

While it concentrates particularly on HIV and AIDS it allows for greater scope and could feasibly be adapted for use with children of parents with a wide range of serious illnesses.

Children have a greater understanding of parental illness and the effects on themselves than we may give them credit for. They may at times have difficulty in expressing their fears and anxieties or they may manifest in other ways. Young children are not always articulate about their concerns. Using this pack will help them, and those working with them, to look at the issues involved.

I enjoyed reading the pack, it gave me a good foundation for working with children affected in this particular way. The guidance notes at the beginning are helpful and I can see it would be important for the user to have a good understanding of the pack before using it.

I feel it helps to have a concise, no nonsense approach to this subject. This is an area which is often neglected in the literature, the focus tending to be on those who have the illness rather than those who may suffer due to someone close to them having it. It is also easy to assume that if you don't tell children about illness they will be ignorant about it. Children are, however, very perceptive especially in situations where something is wrong.

I feel that the authors have achieved what they aim to do; the pack is bright, informative, and user friendly. I would like to see guidance notes for parents included and, for professionals, notes on how to deal with sensitive subjects which may be raised. The section on siblings could be expanded; while there are books dealing with this, the use of worksheets and the ability of parents to discuss this could be of great benefit.

Children can believe that it is their fault that a parent or sibling is ill, that it is because they have done something wrong. This pack will help identify areas where children may have anxieties. Workers will be able to address these areas and help children overcome their problems.

The benefit of this pack is that its use can be expanded over and above its original intention. The sections on viruses and illness can be used for teaching purposes and in

helping younger children in coming to terms with their own illness.

J HUCKER
Sister-ward manager

Neurophysiology and Neuropsychology of Motor Development. Edited by Kevin J Connolly and Hans Forssberg. (Pp 378; £60 hardback.) Cambridge University Press, 1997. ISBN 1 898683-10-7.

This is essentially a text for those involved in research into normal and abnormal motor development in children; in fact it must be considered indispensable to them. The reason for this: a number of leaders in their field give an up-to-date review of the progress made in various aspects of their work, and in a form that would not be available elsewhere. But what of the average reader of this journal? For them it is likely to be used as a reference book when particular problems arise.

Since the advent of various types of brain scan more is being learnt about the results of abnormal brain development causing epilepsy, and mental and physical disabilities; and those caring for these children do need to know how these abnormalities occur. There is also the problem of the normal and abnormal movements of babies, both before and after birth, which may worry both parents and doctors.

More attention is now being given to children who seem to have poor balance and are late in starting to walk, have poor coordination, and are clumsy in their movements. But when do you decide that there is cause for concern? Many answers are given. Of particular value to the clinician are the chapters on children with cerebral palsy. These underline how important it is to avoid dogma, and to be flexible in approaches to treatment. The way in which skills are acquired must be of great significance; and enormous resources are devoted to improving these. If such efforts are to be successful, study of normal development, and of ways in which the damaged brain can compensate will be essential; and all carers will benefit from reading the chapter on the "conversations" between experts and parents, which may be the highlight of

the book as far as practitioners are concerned.

Some of the research certainly emphasises the importance of early learning, especially if motor pathways need to be reorganised. The development of grasping may be of most importance to researchers, but it is also necessary for others to understand how an often used test can vary in the way, and the timing, of its development. The dynamic approach to motor development, and to the acquisition of skills, has considerable appeal, stressing as it does the interaction of so many factors. The mass of information in this book may be daunting, but in the past there is no doubt that many theories, and much of the work, has been oversimplified; and the problems that this complexity presents have to be faced.

One of the purposes of this book is to bridge the gap between different disciplines, and in this it surely succeeds. Another laudable aim is to link scientific work with clinical practice, and this could have been better served if there were a summary at the end of each chapter, or at the end of the book, underlining how this best can be done. This book should reach as wide an audience as possible: and particularly those working with handicapped children will benefit from seeking answers to the questions they will have when faced with the problems of their charges.

NEIL GORDON
Retired paediatric neurologist

Correction

Car restraints and seating position for prevention of motor vehicle injuries in Greece

There were several errors in the manuscript for this article by Petridou *et al* (*Arch Dis Child* 1998;78:335-9).

The title for table 1 should have read: Childhood morbidity (per 10⁶) among car passengers by age group . . . and not as published (Childhood mortality . . .).

In addition, the text that refers to table 1 (page 335, bottom of right hand column; page 338, middle of left hand column) "mortality" should have read "morbidity".