Correspondence

should be a dialogue twixt paediatrician and pharmacist, not houseman and computer.

Reference


J G Davies and B Leivers
Coventry Maternity Hospital,
Walsgrave,
Coventry CU2 2DX

Dr MacMahon comments:

Dr Davies and Mr Leivers comment that they have not found it necessary to make frequent adjustments to their parenteral nutrition regimens and that they therefore usually use one of three standard formulas. I have in the past worked in a major referral unit which used a similar system. I agree that apparently satisfactory parenteral nutrition is indeed possible with such a system when the infant is metabolically stable. There is an inevitable tendency, however, with such a system to either postpone the initiation of parenteral nutrition in the metabolically unstable infant or to tolerate minor electrolyte disturbances rather than alter a standard solution.

In my experience allocating the problem to a senior staff member does not protect against mistakes. In the increasingly complex environment of a modern neonatal intensive care unit errors of all sorts are all too common. I believe that computers should be used whenever possible to help alleviate this problem.

The clinical importance of minor electrolyte disturbances is certainly debatable. In the context of the availability of inexpensive microcomputers I do, however, submit that it is manifestly absurd that arithmetical complexity alone should act as a constraint on optimal clinical management.

Glass furniture hazard

Sir.

We were interested to read Bell’s recent report on glass injuries. About 50 children are admitted each year to the children’s ward at Moorfields Eye Hospital with serious eye trauma and these constitute about five per cent of all admissions to the department. The injuries are caused by a variety of agents, ranging from darts, arrows, balls, bushes, broken glass, and fireworks to airgun pellets, dog bites, drawing pins, scissors, and bomb incidents. The number of serious eye injuries due to broken glass has remained relatively constant in the last few years (see Table), although there have been interesting changes in the traumatising agents.

Just as legislation in the sale of fireworks to minors has led to fewer firework injuries to the eyes, we are now witnessing fewer ophthalmic tragedies due to shattered windshields, presumably attributable to accident prevention propaganda and the recently introduced seat belt legislation. Unfortunately, the new vogue in glass furniture, particularly large coffee tables and glass doors is becoming a major hazard in the home. In the past year we have seen a child who lost an eye and another who required corneal grafting after simple accidents which led to the shattering of glass table tops.

Unlike Dr Bell we feel that educating supervising adults about the dangers of glass in the home gives only partial grounds for optimism in reducing accident rates, as most parents perceive accidents to be outside their control. Improved product design using safety glass in furniture would minimise environmental hazard and probably reduce accident rates. Legislation has had considerable success in accident prevention in other areas and we believe this to be the most fruitful strategy in reducing serious childhood accidents due to broken glass.

References


G F Cole, R B Jones, and M Digby
Moorfields Eye Hospital,
London ECIV 2PD

Table Number of injuries due to broken glass in relation to total admissions due to trauma

<table>
<thead>
<tr>
<th>Year</th>
<th>Total admissions</th>
<th>Admissions due to trauma</th>
<th>No of serious injuries due to broken glass</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>1150</td>
<td>59 (15 girls, 44 boys)</td>
<td>5</td>
</tr>
<tr>
<td>1981</td>
<td>1280</td>
<td>53 (13 girls, 40 boys)</td>
<td>6</td>
</tr>
<tr>
<td>1982</td>
<td>1102</td>
<td>48 (7 girls, 41 boys)</td>
<td>5</td>
</tr>
<tr>
<td>1983</td>
<td>1035</td>
<td>55 (11 girls, 44 boys)</td>
<td>7</td>
</tr>
</tbody>
</table>

Treatment choice in acute rheumatic carditis

Sir.

We read with interest the paper by Human et al regarding steroid treatment in acute rheumatic fever. We also think that steroids should be used in each case of rheumatic fever with carditis, regardless of the severity of the carditis. Two unresolved questions were raised by the authors: the dosage and duration of steroid treatment. Continuous steroid treatment for three weeks, as practiced by Human, may cause suppression of the hypothalamic-pituitary-adrenal axis, with all its consequences. Furthermore, as the natural history of rheumatic fever is six to eight weeks, it is recommended that treatment be given for this period.

To overcome these two problems we have been treating patients suffering from rheumatic fever with carditis with alternate day steroid treatment.