Correspondence

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A SENIOR CLINICAL MEDICAL OFFICER

Juvenile discitis

Sir,

Hensey et al 1 seemed unconvinced of the value of antibiotic treatment in their six cases of juvenile discitis. We have seen and treated four children (three under the age of 5 years) in the past four years with clinical, radiological, and laboratory features consistent with the condition as described by the authors (Table). None of our patients were systemically ill, although one, our first, did present with mild glomerulonephritis and in his case a throat swab yielded beta haemolytic streptococci Lancefield group A. All four patients responded to antibiotic treatment. Penicillin was stopped after 10 days in case 1 with recurrence of backache and inability to walk within a week. His symptoms resolved again within a few days of restarting penicillin and flucloxacillin and he remained well after being given treatment for a further 6 weeks. The other three children received antibiotic treatment for 6 weeks by which time the erythrocyte sedimentation rate had returned to normal in each case.

After two years follow up one of our patients had a recurrence of symptoms, but she again responded to antibiotic treatment with ampicillin and flucloxacillin and has since remained well after trauma. Since 1978, penicillin and flucloxacillin for 6 weeks have been offered to all cases. Immobilisation of the spine for a prolonged period has been recommended by some authors3 4 but we did not find this necessary in any of our patients.

M P SHAH AND C G MILLER
District General Hospital,
Lovely Lane,
Warrington WA5 1QG

Dr Hensey and co-workers comment:

Drs Shah and Miller confirm our opinion that the treatment and origin of juvenile discitis are controversial.1 In the patients we described we failed to find any haematological or bacteriological support for an infective...
Pancuronium bromide induced joint contractures in the newborn

Sir,
I was interested to read that Drs Sinha and Levene have recently described four cases of joint contractures in the newborn which they associate with the use of pancuronium bromide. I note, however, that in the three cases they describe, these babies also received other drugs. They do not mention the route by which they received these drugs. If the route of administration was intramuscularly, I would postulate that this may be a factor that they fail to mention at all in their discussion. I recognise the development of muscle fibrosis as a result of repeated intramuscular injections in neonates. Presumably this could be severe enough to cause a joint contracture.

Reference

Drs Sinha and Levene comment:
We apologise for not having made it clear that all injections given to the three infants described were given by the intravenous route.

Bronchodilators for wheezy infants

Sir,
We were interested in Dr Silverman’s detailed review of the problems of wheezing in small children. We were disappointed that no specific mention was made of the possible beneficial effects of cow's milk free diet in the management of chronic wheezers in the very young age group. We have found this beneficially useful and more acceptable than drug treatment.

In the discussion of bronchodilator treatment Dr Silverman makes no mention of beclomethasone dipropionate (Becotide) which we have used in a nebulised form in a dosage of 50 to 100 μg 4 hourly for wheezy children in this very young age group. We have found some success using this drug in this form and would be interested in Dr Silverman’s views.

J A SILLS AND F G ORY
Alder Hey Children’s Hospital, Eaton Road, Liverpool L12 2AP

Dr Silverman comments:
My remit was to write about bronchodilators for wheezy infants. The topics mentioned by Drs Sills and Ory, the dietary management of wheezy infants and the use of nebulised steroid treatment, are both interesting and controversial. A recent review dealt with the bloody topic of cows’ milk free diets in allergic children. The place of inhaled steroids in the management of wheezy infants would merit a separate detailed review.

References

Minimum standards of neonatal care

Sir,
Working as a senior house officer in three different neonatal units recently and comparing notes with friends in other units has made me realise what a variety of protocols are followed in dealing with babies with meconium liquor and good Apgar scores. The most aggressive comprise routine endotracheal suction preceded by chest compression and followed by bronchial lavage, while the least go no further than oropharyngeal suction. In the last 10 years three published studies have tried to find out what protocol is best and produced two different answers. A review on the subject says that an aggressive protocol is current policy. The standards of neonatal care recently