A fumigatus IgG antibody would thus be difficult to elucidate.

We think that raised IgG antibody to A fumigatus in cystic fibrosis is in most instances probably a secondary event in damaged lungs with chronic infection. There is a risk in some patients for the development of allergic bronchopulmonary aspergillosis (ABPA) which should be carefully investigated in every patient with cystic fibrosis. The role, if any, of IgG antibodies to A fumigatus in absence of ABPA remains to be established as Forsyth et al say.

References

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Coarctation of the aorta corrected during the first month of life

SIR,

In their review of coarctation of the aorta presenting in the neonatal period, Ehrhardt and Walker emphasise the life threatening nature of this condition and the need for urgent referral to a hospital where confirmatory investigation and surgical correction can be performed.1 They also point out that many babies arrive at their centre in poor condition and reiterate that initially an important clue to the diagnosis is the observation of a difference between blood pressure in the right arm and the lower limbs. No figure is suggested for the magnitude of this disparity but it is usually considered to be significant if greater than 20 mm Hg.2

Sphygmomanometric measurement of blood pressure in the newborn is not easy and many neonatal units have come to rely on electronic instruments which employ an oscillometric technique, such as the Dinamap (Critikon). The Dinamap, however, has been shown to overestimate blood pressure in some hypotensive infants,3 and we have recently seen two normally grown term babies with coarctation in whom the Dinamap 8100 gave misleading results in the lower limbs. Both patients presented with heart failure and absent femoral pulses in the first week of life and despite the use of appropriately sized cuffs the blood pressure readings in the lower limbs were almost identical to the normal value obtained in the right arm. From our experience it appears that in cases of coarctation the Dinamap can overestimate blood pressure in the hypotensive lower limb and thereby obscure the underlying diagnosis. If absent femoral pulses suggest coarctation but the Dinamap shows no significant difference between upper and lower limb blood pressure, urgent referral to a cardiothoracic surgical centre should not be delayed.

References

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Accidental feeding of a dilute antiseptic solution to five babies

SIR,

Five normal newborn breast fed babies were accidentally fed a dilute antiseptic solution (chlorhexidine 0·05% with cetrimide 1%) in place of sterile water and developed caustic burns of the lips, mouth, and tongue within minutes; one baby became quite severely ill due to acute pulmonary oedema, but all survived without sequelae.

A full account of this incident in 1976 has been published elsewhere,1 but I would like to draw it to the attention of a wider paediatric readership. Babies at this hospital are routinely given 'top ups' of sterile water if necessary after feeding from the breast so as to allay parent’s fears but not so as to give a feeling of satiety—thus encouraging them to feed from their mothers; this avoids the pitfalls of giving top ups of cows’ milk formula or glucose solution.

The five babies developed symptoms almost simultaneously, and a rapid inspection of the Milk Room showed that, in addition to sterile water, glucose solution, and proprietary milk feeds, there were a number of full and empty clear 50 ml bottles of a dilute antiseptic solution of chlorhexidine 0·05% with cetrimide 1%. This was normally supplied in 500 ml fluted opaque glass bottles, which were temporarily unavailable, so the suspicion was that the antiseptic solution had been given as a top up feed.

References
Correspondence

It is likely that the babies’ symptoms were mainly due to the caustic action of cetrimide 1\%\textsuperscript{2,3}; fortunately contact with the mixture was necessarily very brief as it is irritant with an unpleasant taste leading to immediate attempts to spit it out. Treatment should consist of avoiding gastric lavage; whole egg mixed in milk can be given to neutralise chlorhexidine, but there is no specific antidote to cetrimide. Four affected babies were given hydrocortisone and ampicillin sodium intramuscularly, and two who were irritable were given intramuscular phenobarbitone.

Effect of misoprostol on fat malabsorption in cystic fibrosis

Sir,

The improved fat malabsorption shown in the patients with cystic fibrosis reported by Robinson et al is interesting and significant but the data presented are inadequate to make a judgment as to the drug’s place in patient management.\textsuperscript{1} A study of this type should include the number of pancreatin (Pancrease, Ortho-Cilag) capsules taken by the patients. The fact that only three patients achieved better than 85\% absorption and six suffered from ‘chronic abdominal pain’ suggests that their malabsorption was inadequately controlled due to inadequate dosing with Pancrease; perhaps an increase in Pancrease would have been more appropriate than the addition of misoprostol, yet another medication for their already overloaded treatment regime.

If the absolute values of intake, output, and enzyme dose are not included it is impossible to confirm that these patients were receiving too small a dose of enzymes to control their malabsorption at the start of the study as appears to be the case.

It would be unfortunate if physicians responsible for patients with cystic fibrosis were to add misoprostol rather than treating their patients’ malabsorption correctly—that is, increasing the dose of modern pancreatic microsphere preparation until symptoms are controlled, then checking the faecal fat output and intake. If the fat absorption is less than 90\% the dose of enzyme should be increased and the process repeated. The manufacturer’s literature is misleading as many patients require 6–10 capsules per meal of the microsphere preparations available in the United Kingdom. It would then be of interest to know if the addition of misoprostol to the treatment of patients with cystic fibrosis having optimal control of their malabsorption by conventional preparations would further improve their fat absorption.

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References

\textsuperscript{1} Parks YA, Aukett MA, Murray JA, Scott PH, Wharton BA. Mildly anaemic toddlers respond to iron. Arch Dis Child 1989;64:400–1.


Mildly anaemic toddlers respond to iron

Sir,

Some general readers might be tempted to conclude from the paper by Parks et al that, after oral iron treatment, a change in mean haemoglobin concentration from 108 g/l to 126 g/l, mean corpuscular volume from 64·8 fl to 69·3 fl, and mean serum ferritin from 8·3 μg/l to 14·8 μg/l constitutes ‘iron deficiency, end of haematological story’.

This will of course be far from the case in some Asian toddlers.

Haemoglobin A2 and F determination will not exclude \(α\) thalassaemia, which occurs with high frequency in Asian populations. A mean corpuscular volume of 69·3 fl is below the 3rd centile quoted by Dallman and Siimes,\textsuperscript{2} whose reference group ‘may well include iron deficient children’ as Parks et al point out themselves. From the data they present, some of the children could well have \(α\) thalassaemia, which can coexist with iron deficiency. At the very least their families could be investigated. What diagnoses did they make in those whose mean corpuscular volume remained substantially lower than the mean of 69·3 fl (the SD was 3·9 fl) after iron treatment?

References

\textsuperscript{1} Parks YA, Aukett MA, Murray JA, Scott PH, Wharton BA. Mildly anaemic toddlers respond to iron. Arch Dis Child 1989;64:400–1.