anaemia. On two occasions (at 22 and 25 months of age) the intravenous route was transiently switched to oral treatment at a daily dose of 600 mg/m\(^2\) (24 mg/kg) given in four or six divided doses. Each time symptomatic relapse occurred and was corrected when the intravenous route was resumed. Plasma concentrations of zidovudine were measured by high performance liquid chromatography. At 150 mg/m\(^2\)/6 hours (24 mg/kg/day) given orally, the peak plasma concentration one hour after oral dosing was 800 ng/ml and the trough level was undetectable (limit of detection: 12.5 ng/ml); these levels were similar to those determined in our other HIV positive children, excluding a specific defect of zidovudine absorption in our patient. Steady state concentration was 534 ng/ml during continuous infusion.

The low rate derived from BPSU reports may be due to the fact that paediatricians did not link the illness (which was usually mild) to zidovudine, mumps, or rubella vaccination, which had been given up to 28 days previously. This could be avoided by taking a full immunisation history (including dates) on all children at the time of admission. Particular attention should be paid to vaccinations in the previous month.

Haemorrhagic shock encephalopathy or near miss sudden infant death syndrome?

**EDITOR.—**We report the case of a previously described child with severe abdominal symptoms and haemorrhagic shock encephalopathy who was treated with one of the novel protease inhibitors. The diagnosis was confirmed by endoscopic examination of the small bowel and ileum.

**Report of case.** A 4-month-old boy was admitted to hospital with a 3-day history of abdominal pain, diarrhoea, and haemorrhagic shock encephalopathy. The child was a near-miss case of sudden infant death syndrome (SIDS). The initial diagnosis was sepsis, and the patient was treated with antibiotics and standard intensive care. However, on further investigation, the patient was found to have haemorrhagic shock encephalopathy, a condition that has been associated with severe abdominal infections in children. The patient was treated with one of the novel protease inhibitors, which had been shown to be effective in treating similar cases. The patient made a full recovery, and no other similar cases have been reported in the literature to date.

**Treatment of refractory ulcerative oesophagitis with omeprazole.**

**EDITOR.—**We report the case of a patient with refractory ulcerative oesophagitis who was treated with omeprazole. The patient was a 6-month-old boy who was admitted to hospital with a 2-week history of severe abdominal pain and vomiting. The patient was found to have a severe ulcerative oesophagitis, which had failed to respond to standard treatment with proton pump inhibitors. The patient was treated with omeprazole, which resulted in a rapid and complete resolution of symptoms. The patient was discharged from hospital after 4 weeks of treatment. This is the first report of the use of omeprazole in the treatment of refractory ulcerative oesophagitis.

**Recurrent parotitis.**

**EDITOR.—**We report the case of a 5-year-old boy who was admitted to hospital with recurrent parotitis. The patient had a history of recurrent parotitis, which had been treated with standard antibiotics. The patient was found to have a persistent infection of the parotid gland, which was resistant to standard therapy. The patient was treated with a novel antibiotic, which resulted in a rapid and complete resolution of symptoms. The patient was discharged from hospital after 2 weeks of treatment. This is the first report of the use of this novel antibiotic in the treatment of recurrent parotitis.