The preparation used by Shield et al had the same concentration of anticytoplasmic titres as preparations used and reported by other authors.1 As the patient died six months after being on the treatment, it may not be clear whether the patient had been administered the same concentration of anticytoplasmic antibodies or not.2 Significant reinfection may have been detected at some point in the future had the patient lived. It was not clear whether serum immunoglobulins had been abnormal during the course of the study and neither whether human serum immunoglobulin had been administered at any point; these are factors which may have had bearing on the clinical course.

It has been observed that colostrum contains significant concentrations of non-antibody immunologically active compounds including glycoconjugates that may have activity against cryptosporidia.3 The pathophysiology of cryptosporidiosis is unclear and lack of effective mucosal antibody may be only one part of a complex disease process. This may be why diverse approaches to enteral immunotherapy have all shown promise. There are no data available so far to confirm that one preparation is superior to another in the management of crypto- sporidiosis affecting immune deficient patients and I believe that continued single case reports will not clarify the situation. Controlled trials may enable comparisons to be made between different enteral preparations only in terms of effectiveness but also cost, palatability, dosage, and duration of treatment.

Paul Heaton

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Inappropriate prescribing of promethazine in infants

EDITOR,—Several publications have indicated a possible link between phenothiazine administration and some cases of sudden infant death syndrome (SIDS).1 Prompted by the observation that four of seven infants presenting to one Belgian hospital with SIDS had received trimipramine in the days before death,2 Kahn and Blum prospectively studied 52 SIDS infants admitted to hospital with hyperpyrexia.3 Infants with a history of cryptosporidium-associated diarrhoea in an acquired immune deficiency syndrome patient after treatment with hyperimmune bovine colostrum.4 Gastronomy 1990; 98: 486–9. 5 Borowicz. Treatment of canine cryptosporidial infection with orally administered human serum immune globulin. J Pediatr 1991; 119: 593–5. 6 Boetsman-Finkelstein M, Finkelstein R. Passive oral immunization of children. Lancet 1989; ii: 1336.


Child resistant packaging and accidental child poisoning

EDITOR,—The introduction of child resistant closures for children’s aspirin and paracetamol preparations in the UK in 1976 led to a significant fall in the numbers of children admitted to hospital for accidental ingestion of aspirin and paracetamol poisoning.1 The Pharmaceutical Society has since recommended that liquid methadone and all solid dose formulations are issued in bottles with child resistant closures (R Odds, personal communication).

We are carrying out a population based study of children attending accident and emergency departments as a result of injuries and poisoning in a district in south London. On the 73 days studied over a one year period, there were three children between 2 and 3 years of age who presented after paracetamol ingestion. They had taken liquid paracetamol, dispensed on prescription, in containers without child resistant closures.

Proprietary brands of paracetamol elixir are supplied with child resistant closures but hospital and private pharmacies dispense prescriptions of generic paracetamol elixir in bottles with plain tops. The reason given for this practice is that a standard child resistant closure design for use with the bottles used by pharmacists for liquid prescriptions has not yet been finalised and made generally available.

Although the number of children reported here is too small to allow the calculation of risk in a population, they did account for nearly 10% of all accidental ingestions in this sample. This suggests that there may be a significant number of children at risk from an avoidable hazard. The Department of Health should be encouraged to ensure that adequate supplies of child resistant closures are produced and that their use for children’s liquid formulations is recommended. Payment for dispensing child resistant closures would include reimbursement of any extra cost involved in using these lids.


Nasal instillation of ‘Olbas Oil’ in an infant

EDITOR,—Proprietary formulations of essential oils are readily available to the public for inhalation and are enjoying an increased popularity as natural remedies. Their toxicity when taken inappropriately by ingestion, ocular or nasal instillation is not generally appreciated. We report a case of nasal instillation.

Case history

A 4 month old boy had had four days of upper respiratory tract symptoms affecting feeding, and a relative had given his mother, a 30 year old woman with three other children, some ‘Olbas Oil’ without the box or instructions. She did not notice the warning against use in infants and put several drops in his right nostril. He immediately coughed, became achyphoecaic, and his colour deteriorated. An ambulance was summoned and he was brought into casualty.

On arrival he was peripherally cold with