poor perfusion. His respiratory rate was 80-90/min with wheeze, inspiratory stridor, central cyanosis, and an oxygen saturation of 85% in air. His heart rate was 160/min and there were profuse oral and nasal secretions requiring suction. The pupils were constricted but the child was too agitated for formal neurological assessment. The cyanosis responded readily to facemask oxygen. Over a period of 24 hours his respiratory rate settled and he remained well saturated in air. However, two hours after admission the boy’s eyes became inflamed and an ophthalmological examination revealed bilateral superficial corneal scarring. There was also a chemical conjunctivitis making it impossible for the infant to open his eyes. The child was treated with regular saline (0-9%) irrigation and chloramphenicol prophylaxis, the inflammation settled over the next four days. Fortunately there was no residual scarring.

We have been unable to find any reports of nasal instillation of Olbas Oil in infants. Olbas Oil contains oils of peppermint, clove, eucalyptus, menthol, and cajub but it is the latter two that are thought to be the cause of the respiratory symptoms. Menthol and eucalyptus are terpenes that if ingested may cause epigastric burning, nausea, vomiting, dizziness, miosis, tachycardia, and a feeling of suffocation. Although dramatic, this may be an isolated and episodic event with no evidence to support person-to-person transmission of the illness.5

Oral poisoning with menthol and eucalyptus oils has occurred in the UK but nasal instillation is more common in Europe where bottles may be confused with normal saline. However, ocular involvement has been described only after direct application of camphor and eucalyptus. In young children nasal instillation causes immediate respiratory distress and agitation. This can lead, as in this case, to ocular administration. In patients with severe respiratory symptoms, needing oxygen or ventilation it is important to get an ophthalmic opinion. Untreated the oils can cause local burning and permanent corneal scarring.

**JPW** is supported by the Joseph Strong Frazier Trust.

JONATHAN P WYLIE
Department of Paediatric Cardiology, Freeman Hospital, Heaton, Newcastle upon Tyne NE7 7DN

FRASER W ALEXANDER
Department of Paediatrics, Newcastle General Hospital, West Road, Newcastle upon Tyne NE6 6BE


**Pseudomonas cepacia**

**EDITOR.—**The spread of Pseudomonas cepacia through hospital populations of cystic fibrosis clinics is an increasing cause for concern. Anxiety has arisen after observations that some patients with previously mild disease experience an accelerated and fatal deterioration in lung function after colonisation with the organism.1 Early surveillance studies in the UK suggested a maximum prevalence of 7%,2 however, this has risen in recent reports to approach the 40% described in contemporary studies from North America.3 The organism, which is an environmentally ubiquitous plant pathogen, is nevertheless surprisingly difficult to isolate from the environment; a recent American study only obtained 15 isolates from 900 cultures.

Mounting evidence of person to person transmission4 has led the Cystic Fibrosis Trust to issue guidelines for the management of colonised patients. This advocates segregation for both inpatients and outpatients, with restrictions on socialising and group activities. P. cepacia positive patients, therefore, feel frightened and victimised. To address the concerns within our own clinic we have looked for evidence to support person-to-person transmission of the organism.

Sputum samples from all 118 patients attending both the adult and paediatric cystic fibrosis clinics in Sheffield were routinely cultured for the detection of P. cepacia on Mast P cepacia selective agar (Mast Diagnostics Ltd, Bootle). Suspect colonies were further identified using biochemical and API ZONE system (BioMerieux, Basingstoke). However, as the API ZONE system cannot differentiate between isolates of P. cepacia, ribotyping techniques were employed. Traditional ribotyping detects genomic restriction fragment length polymorphisms by probing the extracted chromosomal DNA with ribosomal RNA. The analysis of DNA rather than phenotypic characters provides a more stable determination of isolate identity.

Ribotyping using the restriction endonuclease enzyme ECO R1 (kindly performed by Dr Ty Pitt; Central PHLS, Colindale, London) was performed on all strains of P. cepacia isolated in 1992/3. The five patients positive for P. cepacia within this period (three of whom were previous positives) had strains with differing ribotype patterns. None of the patients exhibited the ‘epidemic’ S3/PO: ribotype A strain, nor was there evidence of rapid deterioration in pulmonary function in this group of patients with forced expiratory volume in one second (FEV1) essentially unchanged compared with values 12 months before and 12 months after isolation of the organism (table).

Although the modes of transmission of P. cepacia remain unclear, epidemiological evidence from this study suggests person-to-person spread has not occurred in this cystic fibrosis population. In the absence of the epidemic type A strain, strict segregation may not be necessary.

C J TAYLOR
Department of Paediatrics, University of Sheffield, Sheffield Children’s Hospital, Sheffield S10 2TH

<table>
<thead>
<tr>
<th>Change in FEV1, after acquisition of P cepacia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
</tr>
<tr>
<td>No.</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

*FEV1, seven months after isolation. NA = not available.


**BOOK REVIEWS**


This book emanates from the professionals working in the children’s inpatient unit in the Department of Psychological Medicine at the Hospital for Sick Children in Great Ormond Street. It draws on relevant literature and the professionals’ own experience working with young people below the age of 15 who have anorexia nervosa or related eating disorders.

The intention is to fill a gap. Although there are many books about anorexia nervosa, nothing focuses specifically on this age group. The intention appears to be very practical, namely to provide the appropriate background and guidance to those professionals concerned with the direct treatment of children with these disorders.

The book falls roughly into two halves apart from a challenging initial chapter from a parent. The next five chapters review relevant literature concerning the description and classification of these eating disorders, physical aspects, epidemiology, aetiology, and prognosis and outcome. A chapter on assessment is then followed by nine chapters about overall management and the various contributions to treatment including nursing, physical treatment, behavioural and cognitive approaches, individual psychodynamic psychotherapy, group therapy, and finally schooling.

This book is very practical in its orientation and easy to access. Chapters are very clearly structured with a liberal use of headings.

R HOWDEN SMITH
R C SPENCER
Department of Microbiology, Royal Hallamshire Hospital, Sheffield S10 2JF

Arch Dis Child: first published as 10.1136/adc.70.4.358-a on 1 April 1994. Downloaded from http://adc.bmj.com/ on September 17, 2022 by guest. Protected by copyright.

If like me you were a tripe postictically confused after reading about and attempting to understand the different types of seizures, then I would recommend that you read the chapter on seizure disorders in Children with Disabilities.

Like all the various topics covered in this reader friendly book, which is intended for parents and educationalists as well as health care workers, the chapter begins with a set of objectives that the reader will achieve upon completion of the chapter, an introduction which puts the subject under discussion in perspective, followed by a clear description of the conditions (dotted with up to date references) the diagnostic procedures, treatment and multidisciplinary management, and ends with case histories ('based on actual and synthesized cases') and a summary. There are many very helpful illustrations, graphs, and charts (black and white) throughout the book.

Children with Disabilities begins at the beginning with 'the cell' and in a delightfully lucid way explains the basics of genetics, embryology, fetal development, etc. so as to give an understanding of where things can go wrong, and gives a comprehensive coverage of a wide range of topics from the first chapters of the book.

Appendix 'A' provides an extensive glossary, Appendix 'B' is on 'syndromes and inborn errors of metabolism'. Being an American book, Appendix 'C' resources for children with disabilities with North American organisations only; if it were feasible to provide an addendum with a list of British organisations, it would be excellent. Of course, some areas such as hyperactivity would be dealt with differently in British practice.

For such a good sourcebook perhaps a touch of colour would provide an added incentive to lure the reader but I am mindful that this may be offset by a higher cost.

I would have no hesitation in recommending this book to doctors training in paediatrics who need a good introduction to paediatric neurology. This book will be more than adequate to assist with preparation for the Paediatric MRCP Part 2. It will continue to serve the reader well, and there are sufficient up to date and key references in each section for it to be a starting point on the quest for more detailed knowledge about particular topics.

CARLOS DE SOUSA
Consultant paediatric neurologist