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Manganese in long term paediatric parenteral nutrition

EDITOR,—We strongly support the view of Reynolds *et al* that manganese should be measured routinely in all children on long term parenteral nutrition.[1] We would suggest that manganese should also be monitored in patients with prolonged cholestasis who haven't been on parental nutrition. We studied the whole blood manganese concentration and liver function tests in 10 patients with biliary atresia corrected by Kasai operation aged 8 months–17 years (mean 7·5 years). All patients were on normal diet and none had been on parenteral nutrition.

Hypermanganesaemia (>210 nmol/l) was detected in seven of the patients, six of whom had an alkaline phosphatase >1200 IU/l (150–1200 IU/l). In four of them the whole blood manganese concentration was potentially toxic (>360 nmol/l). No specific relationship was found between the blood manganese concentration and that of alanine transaminase and serum bilirubin. All the remaining three patients with normal blood manganese concentrations had normal alkaline phosphatase values. No obvious neurological effects were noted in any of the patients.

As none of these patients had received manganese supplements, these results suggest that the hypermanganesaemia is primarily caused by impaired manganese excretion.[2 3]

The patients studied by Reynolds *et al* had cholestasis as well as being on long term parenteral nutrition. While we agree that it is essential to limit intravenous manganese intake in these children, our study suggests that this alone may be insufficient to prevent or reverse the hypermanganesaemia.

Further work is required to study the effect of chelating agents and/or agents promoting biliary excretion.[4]

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Management of anaphylactic reactions to food

EDITOR,—As immunologists involved in the provision of laboratory services for the investigation of allergic patients as well as patients with other immunological problems, we were concerned to read in Professor David's clinical review of food induced anaphylaxis that some immunology laboratories 'are routinely advising the use of adrenaline syringes for any child who is found to have food specific IgE antibodies (for example, positive RAST to peanut) regardless of the history'.[1]

We wish to emphasise that clinical decisions such as that involved in the provision of preloaded adrenaline syringes must be made only on the basis of a full clinical assessment, preferably by a paediatrician, immunologist, or allergist involved in the diagnosis and management of patients with specific allergic disease. Interpretation of laboratory specific IgE (RAST) test results or skin prick tests, alone and in isolation is problematic as both false positive and false negative results can result from either type of investigation. It is our opinion that provision of direct clinical advice on the basis of laboratory results alone does not constitute good laboratory practice.

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(There were 18 other signatories to this letter representing consultant immunologists and professors of immunology from all regions of the UK and Republic of Ireland.)

1 Patel L, Radivan FS, David TJ. Management of anaphylactic reactions to food. *Arch Dis Child* 1994; **71:** 370–5.

Professor David comments:
We welcome the endorsement that the decision to supply adrenaline syringes should be based on a full clinical assessment. We also welcome the recently published guidelines for good allergy practice from the Royal College of Physicians and the Royal College of Pathologists, which stress the need for paediatricians to be involved in the diagnosis and management of children with allergy or suspected allergy.[1] Perhaps the single most striking feature of running a service for children with suspected food intolerance is the high proportion of children who have other quite different, often important, and treatable disorders.

1 Royal College of Physicians and Royal College of Pathologists. *Good allergy practice. Standards of care for providers and purchasers of allergy services within the National Health Service.* London: Royal College of Physicians, 1994.

The irritable hip

EDITOR,—I read the article on the irritable hip by Fink *et al*[1] and the accompanying commentary by Taylor and Clarke with the prejudice of a parent of a son who had this very painful condition. Fink *et al* suggest a protocol which includes joint aspiration when fluid is diagnosed on ultrasound imaging. Although only one aspirate out of 36 was infected, no less than 28 children experienced immediate relief of hip pain after aspiration.

Taylor and Clarke suggest that benefit from aspiration may be only temporary. How then is more prolonged pain relief to be obtained? My son's earlier attacks were treated in hospital or at home with analgesics which were inadequate. His last attack was after I had joined the staff at Great Ormond Street, and George Lloyd Roberts put him straight into traction with complete relief. Fink *et al* state that traction does not influence outcome but as the prognosis is favourable anyway pain relief is surely the important issue.

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1 Fink AM, Berman L. Edwards D, Jacobson SK. The irritable hip: immediate ultrasound guided aspiration and prevention of hospital admission. *Arch Dis Child* 1995; **72:** 110–4.