LETTERS TO THE EDITOR

Colposcopic genital findings in prepubertal girls assessed for sexual abuse

EDITOR,—We would like to respond to the commentary on our paper.1 The diagnosis of child sexual abuse (CSA) is a jigsaw which includes physical signs and in Leeds is multidisciplinary. The NHS, free at point of contact, health visiting, and case conference systems are important differences between British and US child protection practice.2 In the UK, early referral of cases for paediatric examination and follow up (including re-examination) has taught us much about the programming and evolution of signs. Agreement on physical signs in CSA is likewise evolving here,3 utilising experience with prepubertal girls.4 It is unclear if hymenal perforation of genital findings in child sexual abuse: a new model for America. Child Abuse Negl 1994; 18: 103–6.


9 Hobbs CJ, Wynne JM. Examination findings in legally confirmed child sexual abuse: it’s normal to be normal [Letter responding to Adams et al.]. Paediatrics (in press).


Transfer of critically ill patients with inhaled nitric oxide

EDITOR,—Inhaled nitric oxide (INO), a selective pulmonary vasodilator, has been shown to improve oxygenation and haemodynamic status in cardiorespiratory failure.1–3 However, such patients often become dependent on this treatment during the first few days of administration, making the sudden discontinuation of the INO dangerous. We have so far administered INO to nine patients (ages 6 hours to 4 years) during interhospital transfer to our centre for extracorporeal membrane oxygenation (ECMO). Eight of these have been by road ambulance and one by air ambulance. Six of these patients were neonates with persistent pulmonary hypertension of the newborn and three were older infants and children with respiratory syncytial virus bronchiolitis, acute respiratory distress syndrome, and pulmonary hypertension complicating a cytotoxic adenomatosous malformation of the lung (CAM). Three of the patients were already receiving INO at their referring hospital and could not be weaned before transfer due to marked desaturation (arterial oxygen saturation <60%).

The other six patients were given a trial of INO at the referring hospital by the transport team before transport on ECMO support; all six had a significant response to a test dose of INO (20 ppm x20 minutes) as defined by a greater than 10% improvement in arterial oxygen tension (mean (SE) before INO 67±4 kPa and after INO 103±3 (2) kPa, p<0.05).

There were no complications encountered during the transport of these patients on INO. Four of the patients transferred on ECMO support; all four survived. The other five were left on INO treatment; three survived. The one patient who died had CAM of the lung and the other familial primary pulmonal dysplasia.

During the transports described above, the INO was introduced into the inspiratory limb of the ventilator (Dräger Babilog 2 or Oxymat). With these ventilators gas flow changes with ventilator settings. Therefore changes in parameters such as peak inspiratory pressures, ventilator rate, minute volume and inspiratory:expiratory ratio result in significant alterations to the concentration of INO. For this reason it is essential to monitor continuously the dose of INO being delivered. During transport we measure INO with a portable electrochemical nitric oxide analyser (Bedfont Scientific Instruments) with gas being sampled between the ventilator tubing and the endotracheal tube.

In conclusion, critically ill mechanically ventilated patients can be safely transported on INO. Its ease of administration, rapid clinical effect and apparent lack of toxicity, provides a gas concentration which, made it an attractive additional drug for use during interhospital transfer of critically hypoxic patients. If INO becomes an established treatment then tertiary intensive care units, and in particular ECMO centres, will need to transport such patients on INO. We believe it is essential to monitor continuously INO concentrations during such transfers.

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Microcephaly and childhood non-Hodgkin’s lymphoma

EDITOR,—Between 1968 and 1994 nine out of 194 newly diagnosed cases of non-Hodgkin’s lymphoma in our department had microcephaly. The literature contains reports of associations between non-Hodgkin’s lymphoma and immunodeficiency (congenital and acquired), chromosome instability syndromes, and recombination including microcephaly (Seemanova’s syndrome).1–5


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