It would be helpful if the authors could tell us what proportion of the initial cohort of children with UTI, during 1975 to 1990, underwent initial imaging and later follow-up imaging. We have shown that in an area of very good standard for general practice only a small minority of children with UTI had been referred for radiological investigations. The fact that this ‘denominator’ figure is not provided casts doubt on how representative their results are. The true natural history and prognostic value of different radiological abnormalities (UTI in children) can only be determined on a large scale, prospective, hospital and community based study.

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Dr Utley comments:
I would like to thank Dr Jadresic for her interest in the two papers by Merrick et al. Although the title of these papers refers to Edinburgh hospitals with UTI, either acutely or after treatment, would have undergone imaging of their urinary tract in some form. This has been standard hospital practice and teaching during the whole of the review. Indeed the need for investigation after a single UTI has been the formal recommendation to undergraduates, postgraduates, and general practitioners throughout. Needless to say we have no information regarding children not referred by their general practitioners and we agree with Dr Jadresic that some patients may not have been referred. Large scale prospective and community based investigations are required, and perhaps the impending era of national guidelines and audit will help to answer these thorny questions in the future.

With regard to the letter of Drs Robson and Kelley we do not recommend MUC to be restricted solely to females who have not achieved bladder control. Although it has not emerged as an independent variable for progression of renal disease in young boys, an MUC is clearly an important part of their work-up, particularly after febrile UTI and when abnormalities of the renal tract seen on VUS would be well presented. However, we do feel the indirect voiding study to be a more sensitive, and a substantially less invasive and traumatic way of assessing the presence or absence of VUR in all children who have achieved bladder control and that this now should be seen as the initial test for reflux.

The data presented reaffirm the importance of reflux as a risk factor for progressive renal damage generally and particularly so when associated with infection.

The fact that VUR did not come out as a risk factor for progressive renal damage in boys under 1 year of age, must be due in part to the fact that this particularly vulnerable group did in general receive appropriate antibiotic prophylaxis. A further issue is that renal damage identified at presentation in these young males will represent renal dysplasia, sometimes profound, and for which evidence of progression was difficult to elucidate.

Overall, it would be a pity if debate over appropriate investigation was to overshadow the importance of appropriate clinical follow up and antibiotic treatment and prophylaxis and to that extent we are in total agreement with the final paragraph of Drs Robson and Kelley’s letter.

Non-accidental fracture occurring in hospital

EDITOR.—Recent reports have implied that fractures occurring to infants in hospital are due to natural causes, whereas those occurring out of hospital may be due to non-accidental injury. The inference is that fractures occurring within a place of safety cannot be non-accidental. We report a case of a child who sustained a non-accidental fracture of the left radius and ulnar while in hospital.