Recurrent apparent life threatening events and intentional suffocation

Dr Davis and colleagues comment:

We agree with much of what Dr Samuels and Professor Southall say. Deliberate suffocation must be considered in the differential diagnosis of apparent life threatening events (ALTE) in infants. All paediatricians managing cases of this type must be aware of this possibility and be prepared to follow their local child protection procedures.

Clearly in these cases, paediatricians need the best possible evidence, and if definitive evidence exists, then this is most helpful. It is our view, however, that fabricated illness should primarily be a clinical diagnosis. There is often a wide range of medical factors in the child's background as well as ALTE, and there are usually features in the medical histories of siblings. Close examination of this background can usually enable a clear diagnosis on clinical grounds (on the balance of probabilities). Where a clinical diagnosis can be reached it is appropriate to act without subjecting the child to the risk of further harm to obtain definitive evidence.

Covert video surveillance is undoubtedly both ethical and legally justified where there is genuine clinical uncertainty about whether the child is suffering “medical” life threatening events, or imposed ones, and where a careful review of the clinical history of the whole family does not support a diagnosis of fabricated illness. However, the fact that covert video surveillance revealed abuse in 33 of 39 suspected cases in Southall's own report suggests that the clinical criteria used to select children for covert video surveillance were in fact good indicators of abuse in themselves. This work has been instrumental in bringing deliberate suffocation of children into the public domain and acknowledging that it is an important variety of child abuse. It has also clarified considerably the clinical elements of diagnosis. In light of these reports it is probable that covert video surveillance has become less necessary and a clinical diagnosis without it should now be more acceptable.

Covert video surveillance was used in only a quarter of the cases of non-accidental suffocation within a recent study of the British Paediatric Surveillance Unit (BPSU) study. Of the 26 survivors of suffocation abuse followed up, all of them were initially protected by removal from the home or separation from the perpetrator. At follow up approximately two years later, only three of these 28 children had been allowed home without major conditions being applied (usually involving the exclusion of the perpetrator). Most of these children were subject to Care Orders.

Most of these children were, therefore, protected even though there was no evidence from covert video surveillance. Obviously, the follow up duration and the fact that we obtained our information from paediatricians means we can only draw limited conclusions about the risks of further abuse.

It was not our intention to suggest that clinicians were performing covert video surveillance purely to obtain evidence for a prosecution. However, the BPSU study and anecdotal experience suggest that where covert video surveillance evidence is available prosecution is usual. We agree with Professor Southall that prosecution has various benefits, but Children Act proceedings should allow the protection of children perfectly adequately in most cases.

It is, of course, entirely appropriate for diagnoses of child abuse, clinical or otherwise, to be challenged in court. The complexity of cases of fabricated illness is such that only paediatricians with a major research background in this area should be undertaking these expert assessments. Courts seem, quite rightly, to be becoming more selective in this respect.

We agree that covert video surveillance requires specialist facilities and clinicians who are able to consider both organic and abuse diagnoses. However, we feel that many of these children can be diagnosed on clinical grounds and that not all infants suffering recurrent ALTE would need this service.

Rectal biopsy in the investigation of constipation

We performed a retrospective study of 122 patients with histologically proven Hirschsprung's disease who were treated in our department between 1988 and 1994 (7 years). We found that 8% of our patients had no symptoms in the neonatal period; age at...
onset of symptoms was between 2 and 36 months (mean 7.5 months); this is not a new finding.1–3 Failure to perform biopsy samples in children with late onset of symptoms may delay the eventual diagnosis and could increase the risk of developing enterocolitis. We feel that the study from Southampton1 is based on a very small cohort of patients with Hirschsprung’s disease and that the authors’ conclusion regarding the indication for rectal biopsy is incorrect.

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Infant feeding and atopic disease

EDITOR—I was offended by David’s observation1 that many health professionals are “no more equipped to breast feed than they are to give practical advice on the subject” and that the middle class solution would be to “close the door to the health visitor” and call in someone more appropriate.

Health visitors are skilled practitioners and, apart from during the initial 10 day period when midwives are still involved, do more work with new mothers to promote breast feeding than any other health professional, and are aware of the benefits of breast feeding to the infant and to the mother. However, in the postnatal period it is important that health visitors establish a long lasting professional relationship with the mother. We lose their favour, trust, and respect forever when we are forcing them to make decisions or to continue breast feeding when they are desperate to stop.

Contrary to David’s opinion, health visitors are not ill equipped to offer breast feeding advice. However, we work with the mother to help her adopt the type of feeding with which she is most comfortable. As a result, the mother may choose to change from breast to bottle feeding or, indeed, to mix the two types of feeding. Mothers are aware of the benefits of breast feeding themselves and to the baby, but sometimes they prefer one type of feeding to another because it is more compatible with their lifestyle and commitments. As yet, I have had no success in helping a mother to continue breast feeding when she wants to stop.

Dr David comments:

In reply to Ms Dion’s comments, the following points may be helpful:

• The statement that some families opt for the support of—for example, a National Childbirth Trust trained breast feeding counsellor rather than a health visitor when seeking advice on breast feeding, does not imply criticism of health visitors. It is simply a factual observation.

• It is well known that the quality of practical advice given to breast feeding mothers varies depending on the type of health care professionals (including doctors, midwives, and health visitors) is highly variable and often very poor.1 This may be one reason why some mothers prefer to seek the help of non-health care professionals who fulfill the dual criteria of either having successfully breast fed their own infant or having received training in how to advise breast feeding mothers.

• It is plainly unhelpful to try to force reluctant mothers to continue breast feeding, or to try to impose one’s own ideas as to what is correct.

• Having breast fed ones own baby is unlikely to be the best basis for giving advice to other breast feeding mothers who are having problems. Training is essential. Women who have breast fed their own babies, and who are aware that they are having problems, are more likely to be the best basis for giving advice to other breast feeding mothers.

• I do not believe that mothers and babies should be dismissed as it can a...
Nadel care of young disabled adolescents falters to identify the widely acknowledged view that the permeability oedema. It costs substantially more than starch + + + + + +.

EDITOR,—I disagree with the conclusions of Nadel et al that albumin should remain the first choice as a resuscitation fluid in sepsis. It works not only because of its oncotic pressure effects but may retain water in the circulation better by sealing endothelial gaps. The 250 kD HES has also been shown to have no adverse effect on clotting.

Gelatin do not have the same virtues as HES as they have a short half life with rapid leak into interstitial space and have poor colloid osmotic function. In our paediatric intensive care unit we stopped using albumin more than a year ago. Our standardised mortality (as well as Nadel et al’s) is lower than predicted. Does it follow that the choice of colloid has no influence on the survival of a critically ill child? If so, why use a product with so many potential drawbacks?

SANJIVI NICHANI
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Transitional care of young disabled people

EDITOR,—Fiorentino et al have tried to quantify the widely acknowledged view that the care of young disabled adolescents falling during their transition to adulthood. They have arrived rightly at conclusions which, when implemented, should improve transitional care of chronically disabled young people: this level of care has been delayed in its development by a lack of enthusiasm and initiative by health professionals and their organisational bodies. Furthermore, a significant number of young people with chronic health problems do not have a “statement of special educational needs.”

Last year, I presented findings of a survey of transitional care of chronically ill young people in the South Thames region at a national meeting of community paediatricians.1 This survey was based on 165 questionnaires and 161 practising paediatricians and consultant child psychiatrists from the South Thames region took part. The questions dealt with the current level of satisfaction with transitional care and planned changes in this area as perceived by the participants. The data showed that while only 32% were either frequently or always satisfied with the current transitional care for disabled adolescents, only 90% were worried about changes to the situation. The lack of equivalent adult services were cited frequently as an unmet need.

Recently, the UK Royal College of Physicians3 and the American Academy of Pediatrics4 issued guidance in the organisation of transitional care. We should therefore take this opportunity to persuade the Department of Health and primary care groups to provide organised transitional care for disabled young people.

During the past 20 years, the survival of young critically ill people has improved greatly due to the dedication of, and hard work by, carers as well as health professionals. It would be a disservice to these young people and their carers if we fail to improve service provision during their transition to adulthood.

A SARMAH
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EEG and epilepsy

EDITOR,—We welcome the debate on the timing of EEG examinations.1 The practice of delaying the EEG until after a second seizure began when epilepsy syndromes were unrecognised. The EEG was then of little help in predicting prognosis or guiding treatment, but has been transformed by the recognition of epilepsy syndromes. Although some of these syndromes may be difficult to diagnose,2 other cases, such as benign childhood epilepsy with centrotemporal spikes, and juvenile myoclonic epilepsy, have easily recognised clinical and EEG features.3 It may not be possible to predict seizure recurrence in a child who has had a nocturnal tonic


Attention deficit hyperactivity disorder

EDITOR,—In the management section of his paper on attention deficit hyperactivity disorder (ADHD) which focuses mainly on medication,1 Hill gives the erroneous impression that managing hyperactivity by diet is difficult and ineffective: those who use it regularly to control ADHD know that this is not the case.

Standard diets are not helpful in the management of this disorder because the foods which provoke hyperactive behaviour are different for each child. Few parents succeed in identifying the foods which affect their child without help, but an elimination diet is effective in most cases. Of omega 6 essential fatty acids are common in these children2 so, in addition to the calcium supplement given to all children avoiding milk, evening primrose oil, borago oil, and cofactors such as zinc, are also usually


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recommended. Under this regimen, the hair-
raising first consultation with the child is
often followed by a quiet and cooperative
second or third visit. If they have had help
with finding alternative foods, most parents
find it surprisingly easy to keep the child to
the diet most of the time after the first few
weeks because the child usually prefers to feel
well.

There are three good trials\(^4\) which report
substantial improvement and significant re-
duction of Connor's scores in hyperactive
children on a hypoallergenic diet; over 70% of
children responded in each study. The results
were confirmed with double blind placebo
controlled challenges\(^5\); significantly higher
scores were recorded during periods on chal-
lenge food rather than on placebo. These trials
did indeed use a stringent few-food hypoallergenic
diet during the investigative phase, with very slow challenges. However, in
the clinic, if you start by taking a good history
(preferably when the child is not present), it is
often possible to see good results in hyperac-
tive children fairly quickly and with relatively
few exclusions.

The principles of elimination dieting are set
out in a recent text.\(^6\) Provoking foods or
food additives are usually those which are
eaten frequently; it is rare for a single item to
be responsible for ADHD. Most of the prob-
able provoking substances must be avoided
completely and at the same time to get good
results. It may be sufficient to avoid additives
(specially colours and preservatives in food,
drink, medicine, and toothpaste), chocolate,
milk, and orange, to which most hyperactive
children react.\(^7\) However, reactions to cheese,
heat, and other fruit are also common and
any food may provoke hyperactivity, espe-
cially if eaten frequently. An improvement is
often seen in children within 3–7 days, and
single open oral challenges are usually
sufficient if given within three weeks. Foods
which cause a distinct deterioration in behav-
our should be avoided for several months, by
which time they can often be tolerated if not
eaten frequently. The diet may have other conditions—for example, glue ear or
abdominal pain, which are also present in
many of these children;\(^1\) in boys with eczema
it is sensible to arrange challenges under supervision as there have been reports
of anaphylaxis. Finally, the nutritional quality
of longer term diets should be checked by a
dietician.

If the diet is effective, behaviour often
reverts to normal, to the great relief of all
concerned. In view of the potential toxicity
of medication in children and its limited effec-
tiveness, all families with hyperactive children
should be offered help in detecting offending
foods. It is more appropriate to reserve medi-
cation for those who fail.

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4 Carter CM, Urbanowicz M, Hemley R, et al. Effects of a few-food diet in attention deficit dis-
5 Bors M, Mandel FS. Foods and additives are common causes of the attention deficit hyperac-

Professor Till comments:
Of course an elimination diet works for some
children with attention deficit hyperactivity disorder; I use it myself. I agree that there is good evidence of the effectiveness of the few-food diet, but its effect size is small com-
pared with that of medication. Parents
committed to dietary treatment have usually tried it. Those who are uncommitted may
find it cumbersome. I know of no convincing
evidence that confirms an allergenic mechanism. The approach recommended by
your participants is a mixture of elimination
diets, additive restriction, and magic ingredi-
ents, which has thus far not been tested
scientifically. Nevertheless, I expect that
borage oil is very nice.

Doctors as expert witnesses

EDITOR,—Most doctors do not like giving
evidence in court, and giving an opinion is
becoming more difficult as advocates appear
in more adversarial courts. Doctors acting as
expert witnesses in the cases of alleged child abuse\(^2\) have agreed that there is considerable
utility in this approach as the following case illustrates.

A set of female triplets were initially
referred to one of us (DH) for review and
examination following a disclosure that they had been sexually abused by their father. The
children were examined by colposcopy using a
standard technique of gentle labial traction.\(^2\) Still photographs of the findings were
made with the informed consent of the mother who understood that they would be used
for teaching and training purposes only.

The examination findings were consistent
with previous sexual abuse, but there was
neither disclosure of, nor findings compatible
with, recent trauma.

The photographs were subsequently ob-
tained and discussed at a peer group review
meeting held by North-East London paediat-
tricians who work in child protection at which
we were present. There was a debate as to
whether there were changes in the hymens of
the triplets consistent with sexual abuse or
whether the appearances were due to
vaginal abnormality of the hymen. Un-
known to the peer group members, one of us
(JW) had been asked by the official solicitor
to review the medical evidence.

To resolve these important issues it was
agreed that there should be a joint medical
examination by DH who described the initial
findings, JW who had been asked by the offi-
cial solicitor to comment on the medical
report, and VL who gave an independent
opinion. The mother and children gave
consent. The court granted permission for
the medical to be part of a “precourt” review.
At the examination we agreed that in two
girls the findings were diagnostic of sexual
abuse and in the third strongly supportive of it. No
doctor had to give evidence in court.

These cases illustrate three points. First,
the utility of the peer group review; second,
the difficulties that may arise when photo-
graphic or even video evidence is used; and
third, the positive benefit of joint examination
by experienced paediatricians. None of the
parents reacted adversely to the process and we
were able to discuss the findings with the family and other child protection agencies.

We believe that this case highlights the
importance of pretrial liaison in child protec-
tion work and illustrates the therapeutic ben-
efit of the joint approach.\(^3\)

DEBORAH HODES

Letters, Book reviews

Currently more than 300 children have been enrolled worldwide in an international multicentre randomised trial of bactericidal permeability increasing protein in severe meningococcemia. To gain the maximum benefit from the huge amount of data collected, ongoing registration is required between clinical trials. The formation of a central coordinating group is long overdue.

STEPHEN PLAYFORD
DAVID THOMAS
DAVID WALKER
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Queen’s Medical Centre, Nottingham NG7 2UH, UK

Is prolonged rotavirus infection a common cause of protracted diarrhoea?

EDITOR,—The possible link between rotavirus and the postenteritis syndrome was highlighted in the recent editorial by Mitchell et al. The finding of prolonged rotavirus excretion in the stool using reverse transcription-polymerase chain reaction in children with enteritis is a surprising result. We believe that in this report the authors are looking at a very specific aspect of the infectious process. It is quite clear that prolonged viral shedding is common among young children. If this viral shedding is seen in children with enteritis, the only significant new finding is that this association is not seen in children with other conditions. The identification of viral persistence in enteritis could have important clinical and experimental implications in the understanding of this syndrome.

We agree with the authors that the data presented to date do not make it possible to conclude that prolonged rotavirus excretion is a common cause of the postenteritis syndrome. The results presented are not definitive and further studies are required to clarify this association.

DAVID THOMAS
DAVID WALKER
Department of Paediatrics and Child Health,
Queen’s Medical Centre, Nottingham, England

CMV coinfection and disease progression in vertically acquired HIV infection

EDITOR,—The paper by Boritsin and colleagues provides interesting information regarding the potential contribution of cytomegalovirus (CMV) viral load in HIV-infected children. The significantly higher CMV viral load in the youngest age group (0–2 years) could explain the generally higher mortality in this age group due to the accelerated disease progression. However, the conclusion regarding the progression of HIV infection associated with the CMV viral load in this cross-sectional study should be treated with caution.

Between May 1985 and September 1995 we were able to follow from birth 25 vertically HIV-infected children staged as A or B. We studied the clinical course and morbidity associated with CMV infection during 76 patient years.

Patients were divided into CMV negative (CMV IgG antibody negative and CMV cultures from urine samples; n = 12; median follow-up 42 months) and CMV infected (CMV IgG antibody positive; n = 13; median follow-up 39 months (range 19–68)). In the CMV infected group 10 patients had positive urine samples for CMV on several occasions during observa-
tion. There was no primary CMV infection in the CMV negative group during follow up. Clinical outcome of CMV negative patients was significantly better than CMV coinfected patients (4/12 versus 1/2 patients was significantly better than CMV negative group during follow up. Therefore, a longitudinal study should be performed using CMV viral load to estimate the correlation of CMV and CMV coinfection for disease progression.

**Botryoid neutrophils in unexpected heat stroke**

**EDITOR.—**Heat stroke is a potentially fatal disorder but often difficult to diagnose in children. Peripheral neutrophils with radially hypersegmented nuclei—"botryoid" neutrophils—are known to be characteristic of heat stroke in adults. We describe three children exhibiting botryoid neutrophils who presented with acute encephalopathy.

Patient 1 was a 7 month old girl with severe cerebral palsy who became unresponsive after being kept warm with a hot pack in winter. Before her collapse, her mother had complained of a chill. Her temperature was 40.4 °C, shock, diarrhoea, and bleeding diathesis were evident on admission. (A) patient 1; (B) patient 2; (C) patient 3. (Original magnification ×537).

**Figure 1** Peripheral neutrophil with radially hypersegmented nucleus (botryoid neutrophil) observed acute encephalopathy, shock, diarrhoea, and bleeding diathesis were evident on admission. Despite aggressive resuscitative measures he died 18 hours later.

**Table 1** Laboratory findings of patients exhibiting botryoid neutrophils during acute stage

<table>
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<tr>
<th>Patient</th>
<th>Leucocytes (×10³/l)</th>
<th>Neutrophils (×10³/l)</th>
<th>Haemoglobin (g/l)</th>
<th>Platelets (×10³/l)</th>
<th>PT (seconds)</th>
<th>aPTT (seconds)</th>
<th>Fibrinogen (g/l)</th>
<th>FDP (µg/l)</th>
<th>AST (IU/l)</th>
<th>ALT (IU/l)</th>
<th>LDH (IU/l)</th>
<th>CK (RU/l)</th>
<th>BUN (µmol/l)</th>
<th>CRP (mg/l)</th>
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<th>Pco₂ (torr)</th>
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<td>51.8</td>
<td>1.8</td>
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<td>4960</td>
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<td>&lt; 10</td>
<td>615</td>
<td>712</td>
<td>4120</td>
<td>3670</td>
<td>15.2</td>
<td>&lt; 3</td>
<td>6.88</td>
<td>17.5</td>
<td>35 to 45</td>
</tr>
</tbody>
</table>

*Fell by more than 30 g/l within 3 days after onset.

Despite aggressive resuscitative measures he died 18 hours later.

**Table 1** shows the laboratory findings of the three patients. In the presented blood smears neutrophils had botryoid changes of 1% (patient 1), 50% (patient 2), and 2% (patient 3) (fig 1). Patients 1 and 2 did not have botryoid neutrophils on day 2. In patients 1 and 2, all bacterial cultures were negative. In patient 3, blood culture was positive for Pseudomonas aeruginosa but no lesions of pseudomonas infection were detectable in any organs at necropsy. Patient 2, a rise in haemagglutination inhibiting antibodies against influenza virus A was detected.

Although the thermal condition was different in each case, these patients shared clinical features typically seen in heat stroke including acute encephalopathy, shock, diarrhoea, raised liver and muscle enzymes, azotaemia, coagulopathy, and high fever. Botryoid neutrophils have been observed in haemorrhagic shock and encephalopathy syndrome (HSES), which is a fulminating encephalopathy syndrome of HSES, which is a fulminating encephalopathy syndrome (HSES), which is a fulminating encephalopathy syndrome. Therefore, botryoid neutrophils may represent atypical forms of HSES. Heat stroke may easily be misdiagnosed as infectious encephalopathy because children, as with patients 2 and 3, frequently have clinical evidence of infection. Our observations suggest that detection of botryoid neutrophils may help in the early diagnosis of heat stroke including atypical HSES in children who present with acute encephalopathy.

The diagnosis of haemophilia in a newborn son often leaves parents feeling completely overwhelmed. Many mistakenly believe that a simple scratch in a boy with this congenital bleeding disorder can lead to death through exsanguination, or that their son will end up in a wheelchair because of early arthritis. In fact, the prognosis for young people with haemophilia is excellent, and boys in developed countries now look forward to an essentially normal life. The introduction of recombinant coagulation factor concentrates has eliminated the risk of transmission of viral infections such as HIV or hepatitis, and it is now usual practice to give factor VIII on a regular, prophylactic basis to prevent most spontaneous bleeds, and thus long term disability. Haemophilia actually confers protection against coronary artery thrombosis, which is the principal cause of death in middle-aged men.

Haemophilia is a relatively rare disorder, affecting approximately 6000 boys and men in the UK. Few doctors and nurses will have experience of dealing with a condition that affects only 1 in 10 000, and parents may be frustrated by difficulty in finding answers to their many questions. This book distils the personal experience of a paediatrician, which extends over 30 years, in the treatment of this rare disorder. The book is primarily aimed at the parents of boys with haemophilia. However, it will undoubtedly also be an invaluable source of reference for all health care professionals or others (such as teachers) who come across children with haemophilia. The value of this book is reflected in the fact that the book is now given as a gift to all parents registering for the first time with the Haemophilia Society, the national patient charity. The basic medical facts about blood clotting and haemophilia are clearly set out, and excellent illustrations help to get the basic message across. There is comprehensive advice on matters about management of all bleeding problems, with specific advice on exact dosage of coagulation factor concentrate. There is also general advice on issues such as employment and travel. There is a section aimed at female carriers of haemophilia, with up to date information on the latest methods used for genetic identification of carriers as well as antenatal diagnosis of haemophilia. It may come as a surprise to some to learn that boys with haemophilia are now positively encouraged to participate in sports at school, and this book gives very sensible advice on which sports are to be encouraged (such as swimming and tennis) and those that are best avoided (such as hockey and rugby).

A programme of physical exercise helps to maintain muscle strength and prevent joint bleeds. People with haemophilia should not take aspirin, which exacerbates the bleeding tendency, and I am sure that patients will find the list of almost 600 over the counter products that contain aspirin very useful.

This 5th edition was first published in 1995 but is now available in paperback for the first time. This is a rapidly moving field and some significant recent developments are not covered in the book. Recombinant factor IX is now available for all young patients with haemophilia B, and recombinant factor VII is now licensed and has proved to be invaluable in the treatment of the minority of patients with inhibitory antibodies. However, this is an excellent, comprehensive, and well illustrated book that will be invaluable to all who come into contact with boys with this rare condition.

PAUL GIANGRANDE
Consultant haematologist


Although immunisation is one of the most effective forms of medical intervention, the increasing scepticism with which it is viewed by a significant number of parents means that those involved in the process need to be fully informed.

The authors of Immunizing children acknowledge the stimulus provided by parents, their questions, and their reluctance to accept immunisation. This book appears to provide a bridge between the “Green book” Immunisation against infectious disease (London: HMSO, 1996) and the consumer.

The early part discusses vaccine development (trial phases), and explains the immunological background, before going on to describe the characteristics of the preventable infections. There is a section on immunisation schedules, considerations and contraindications, immunisation procedures, and care of vaccine recipients. The book considers reactions and parents’ questions.

This book is in many respects less comprehensive than the “Green book”. The descriptions of the reactions are irritatingly simplistic and at times show ignorance of current practice: thus epiglottitis resulting from Haemophilus influenzae type B infection is described as...inflammation of the throat which blocks the entrance to the wind pipe. Children...died by suffocation unless they were immediately treated by antibiotics and in some case by a tracheostomy. Tracheostomy has not been used as treatment for many years. Similarly rubella and diptheria are said to cause heart damage and this rather simple approach has led to important omissions—no mention of the serious consequences of measles in the immunosuppressed child. Egg allergy is a common problem in children yet it is covered in a short, rather uninformative paragraph.

The section on common worries will be useful to health professionals who have to reassure parents about measles—mumps—rubella, Crohn’s disease, and autism. Some background references in this section would have been useful.

This book is a useful addition to the literature on immunisation. I suspect its greatest benefit will be to the professional who needs information for the sceptical parent.

P T RUDD
Consultant paediatrician


A revised translation of a German textbook first published in 1995 has been transformed into this edition. The book is targeted at radiologists who undertake some imaging of children. It may also be of interest to paediatricians in general as the numerous (over 1500) images cover a wide range of conditions.

The format consists of lists of possible differential diagnoses for a variety of imaging findings—for example, bilateral renal enlargement without pelviccalyceal dilatation. This is a relatively novel approach to a radiological text and by and large it works well. A three column table is employed to discuss the general headings and their differential diagnoses. Some brief additional text and normal anatomical measurements are included at the beginning of each chapter or subchapter. The book also contains numerous anatomical diagrams and schematic drawings, which are superb and greatly facilitate a rapid understanding of the subsequent text. The tables are simply laid out, contain a sensible amount of information, and are easy to sift through. Overall, this is an excellent book. The authors and publishers are to be congratulated for a number of reasons. The English translation is virtually faultless, the images excellent (always hard to achieve with plain radiographs), and the general layout is easy to follow. The aim of the book is an aid to differential diagnosis when confronted with a radiological finding in a child, although the major strength is really in the large selection of good quality plain films and other images.

A few deficiencies just about merit mentioning. A laudable attempt at brevity has resulted in staccato, one word sentences in the comments section. This approach can occasionally be quite confusing and there is a good understanding of the disease processes being discussed. Although a relatively large book, the emphasis is on images and so inexperienced trainees will need to look elsewhere for in depth discussion of the pathology illustrated. There is too little nuclear medicine particularly in the genitourinary chapter, which does not reflect modern paediatric radiology or urology practice, which now relies heavily on nuclear medicine techniques. The section on gastrointestinal radiology would benefit from some better editing of the text to match the high standard of the rest of the book. Ultimately these drawbacks do not seriously detract from what is otherwise an excellent and extensive collection of paediatric images allied to relevant sensible tabulated information.

KIERAN MCHUGH
Consultant radiologist

The author of this latest addition to the Eponyms in medicine series is a distinguished Irish professor of paediatrics, well known for his interest in mental handicap. He has been honorary medical advisor to the Down Syndrome Association of Ireland for 20 years. Conor Ward is to be congratulated on this first full and vivid biography of a remarkable and somewhat neglected Victorian physician.

John Langdon Down, MD, FRCP was born in Cornwall in 1828, the son of an apothecary. Entering medicine in 1853 he was a brilliant student and qualified at the University of London in 1858. At once he was appointed superintendent to the Royal Earlswood Asylum for Idiots. Careful observation and the use of clinical photography enabled him to attempt a classification of children with mental retardation. He was the first to describe both the Prader–Willi syndrome and, in 1866, the characteristics of mongoloid idiocy, which, 95 years later, came to be known eponymously as Down’s syndrome.

In 1868 Langdon Down opened his own private institution for mentally retarded children, Normansfield. There he worked till his sudden death at the age of 68 in 1896. His work was then continued by his sons Reginald and Percival, and by a grandson, until the institution was absorbed into the National Health Service in 1952.

Langdon Down was a large handsome man with charming manners and liberal views. A pioneer in the humane caring for and treatment of people with learning disabilities, he had a natural empathy with the handicapped. In this as in other ways he was ahead of his time. He was a strong advocate for the rights of women and for their higher education. He served on the board of the Society to Abolish Capital Punishment. He became a Justice of the Peace and in 1889 was awarded the Order of St John.

This slim volume is well illustrated, referenced, and indexed. It is warmly recommended to all those having an interest in the history of medicine and in the care of those with mental retardation.

P M DUNN
Professor of Paediatric Medicine and Child Health


The evidence provided by the diabetes control and complications trial (DCCT) exerts considerable pressure on clinicians to help their patients achieve optimal blood glucose control. This book has been written to provide detailed information for primary care physicians who, due to shifting responsibilities in the USA away from specialist teams, are becoming increasingly involved with the care of children with diabetes.

Initially, the book appears rather wordy, having few diagrams and no pictures. However, it is not always the books with the most lavish illustrations that prove most use to the novice learning a craft. This book, while not forgetting some scientific information, is about the practical aspects of managing childhood diabetes. It is written in a sensitive manner, is easy to read, and the many brief case studies provide useful and interesting verbal illustrations. I was glad to find that, despite the transatlantic differences, we share a common philosophy of care, and most of the subject matter is as relevant in the UK as in the States. Professor Plotnick’s empathy with the children and their families is evident throughout the book, and social and psychological issues feature alongside the day to day diabetes management. There are chapters by a dietitian and nurse educator, and an appendix that contains a variety of sample record forms and letters, a reading list, and web sites.

I get the impression that American families are encouraged to work harder at perfecting their diabetes management than their British counterparts, although it was sobering to note that personal finances and insurance policies may restrict some families’ ability to do this. Much is expected of them especially where meal plans and monitoring are concerned. Detailed instructions are given for altering insulin doses, and intensive monitoring and accurate record keeping are emphasised to achieve good control. I was intrigued to learn that when blood glucose concentrations are out of target range it is possible to determine the decrease of blood glucose produced by one unit of insulin by using “the 1500 rule”. This entails dividing 1500 by the total daily dose of insulin to calculate how many mg/dl one unit of insulin will decrease blood glucose.

Diabetes nurse educators appear to work in much the same way as specialist nurses in the UK; however, I would have liked to learn more about their teaching methods and aids with perhaps some illustrations. It was interesting to see a whole page devoted to drawings of different sizes of syringes and needles but none of pen devices that are “very popular in Europe” or pumps, which are used more by American children.

This book will be of interest to all practical clinicians caring for children with diabetes, but more will be gained by reading it in its entirety before delving for specific information. Some phrases remain in my mind which could sum up its ethos: “thinking like a pancreas”, the “relentlessness of diabetes” and “keeping hope alive”.

SALLY STRANG
Paediatric diabetes specialist nurse


The written paper of the MRCPI part II examination (member of the Royal College of Paediatrics and Child Health) consists of three sections: case histories or “grey cases”, visual material, and data interpretation.

The current market boasts a multitude of excellent reference atlases and examination orientated picture books that between them offer a staggering array of clinical photographs. Conversely, there are only several challenging books of case histories and, as yet, even fewer texts for data interpretation.

Although practice promises to make perfect, this is perhaps a more realistic target to attain in the analysis of data questions than in answering the case history section, which does tend to retain a murky quality peculiar to itself. This book will certainly aid one in developing a critical approach to data problems, and the importance of achieving confidence and maximum scores in this section cannot be overemphasised in an examination which, so often, is lamentably unpredictable.

The questions in this book cover a broad spectrum of topics and manage to include problems referring to recently implemented investigative techniques in medicine as well as to conventional “bedside tests”, of which few junior doctors these days have actual clinical experience. In recent years there has been a growing representation of neonatology questions in the examination as well as the increasing employment of figurative data in the form of EEGs and ECGs, and the complex numerical data of cardiac catheter measurements and pulmonary function tests. These trends are adequately reflected by the choice of questions in this book. Subjects such as epidemiology and genetics, which are all too frequently stumbling blocks, are addressed in a comprehensive manner.

The overall standard of questions is comparable to that faced in the actual part II examination and the answers are succinct with appropriate references to the standard paediatric textbooks. Thankfully, it avoids making the common error committed by many textbooks for postgraduate qualifications, which aspire to be so difficult and esoteric that one loses all faith in one’s ability ever to pass the examination.

Furthermore, Data interpretation fits snugly into a jacket pocket, making it a handy companion on train journeys or for quiet moments on call when revision beckons.

Having recently sat, and fortunately passed, the MRCPI part II, I would thoroughly recommend this book to potential candidates. It is one of the few question books that I had the time and the heart to reread just before the examination in that critical period when one needs to revise material in the shortest possible time while simultaneously suppressing an ever growing sense of panic.

Finally, I believe that this is a useful text even for those who have left the spectre of postgraduate examinations far behind. I am sure that a surprising number of new facts may be gleaned from perusing these pages and, after all, the process of self education by no means ends with membership.

SHARMILLA DIAS