LETTERS TO THE EDITOR

Palivizumab and RSV prevention

EDITOR,—The letters from Drs Deshpande and Nicholl, in relation to the IMpact-RSV study and the UK guidance for the use of palivizumab in the prevention of serious RSV infections, raise interesting questions that need to be addressed.

I believe Dr Deshpande “has got it wrong” in that he fails to realise that the primary objective of the IMpact study was to investigate whether palivizumab reduced RSV hospitalisations in high risk infants. It was never intended that this study would address the severity of RSV infections, the need for paediatric intensive care, the need for mechanical ventilation, or a reduction in death rate. It is unreasonable to suggest that because the study didn’t show these then it is not valid. To show such benefits would require a totally different protocol, the numbers of patients being such that the study could never have been undertaken.

To reiterate the findings of the IMpact study, there was a 55% reduction in hospital admission rate for RSV proven disease—a significant result, however one wishes to interpret it. Those high risk patients admitted with RSV infection spent fewer days in hospital, had less need for oxygen treatment, and had lower respiratory infection clinical scores if they received palivizumab.

The study was designed in association with and with the approval of the licensing authorities in order to help better define many of the vulnerable patients the benefits of scientific advance.

WARREN LENNEY
Academic Department of Child Health,
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Stoke-on-Trent ST4 6QG; UK

Rapid responses

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The editors will decide, as before, whether to also publish it in a future paper issue.

### Rapid responses

**Palivizumab and RSV prevention**

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### Letters to the Editor

Letters to the Editor are to be used for correspondence regarding a published paper in *Arch Dis Child*. The type of letter should be selected as ‘Letters to the Editor’ when submitting a paper through the online submission system. Letters will be reviewed and may be rejected if not appropriate for publication. Publication is not guaranteed. All letters are subject to the same review process as papers. The length of the letter should be limited to 300 words, 10 references, and 5 authors. Authors will receive proofs. Each letter will be limited to one column in size. Letters must be original and unpublished, and may not be submitted for publication elsewhere during the review process. Letters should state clearly whether the correspondence is intended for rapid response or for general publication. The text should be identified as a letter to the Editor for all correspondence. All submitted letters will be subject to peer review by members of the Editorial Board and/or the Clinical Editors who will be assigned to handle the letter. Letters may be edited for reasons of clarity, correctness, conciseness, and coherence. All authors will receive proofs. Each letter will be limited to one column in size. Letters must be original and unpublished, and may not be submitted for publication elsewhere during the review process. Letters should state clearly whether the correspondence is intended for rapid response or for general publication. The text should be identified as a letter to the Editor for all correspondence. All submitted letters will be subject to peer review by members of the Editorial Board and/or the Clinical Editors who will be assigned to handle the letter. Letters may be edited for reasons of clarity, correctness, conciseness, and coherence. All authors will receive proofs.
cause high levels of morbidity and significant mortality in high risk infants.

CHRISTINA CARNEGIE
Medical Director, Abbott Laboratories Ltd, UK

3. Palivizumab, a humanized respiratory syncytial virus monoclonal antibody, reduces hospitali-
   zation from respiratory syncytial virus infection in high-risk infants. The IMpact-RSV Study
4. Reduced respiratory syncytial virus hospitali-
   zation among premature infants and infants with bronchopulmonary dysplasia using respira-
   tory syncytial virus immune globulin prophylaxis. The PREVENT Study Group. Pediatr 1997;
5. Groothuis JR, Simoes EAF, Levin MJ. Prophy-
   lactic administration of respiratory syncytial virus immune globulin to high-risk infants and
6. Groothuis JR, Simoes EAF, Hemming VG. Res-
   piratory syncytial virus (RSV) infection in pre-
   term infants and the protective effects of RSV immune globulin (RSVG). The Respiratory Syncytial
7. Groothuis JR, Gurevitz RM, Lau BA. Respiri-
   tory syncytial virus infection in children with bronchopulmonary dysplasia. Pediatr 1988;
8. Joffe S, Escobar GJ, Balck SB et al. Rehospitali-
   zation due to respiratory syncytial virus in pre-
   (Synagis) —Expanded access study in 1998–
    humanised antibody for protection from RSV lower respiratory tract affection [abstract
11. Soll RF, Jacobs J, Paishio S et al. Cost effective-
    ness of breast-feeding in the prevention of respira-
    tory distress syndrome. Pharmacoeconomics
12. American Academy of Pediatrics Committee on Infectious Diseases and Committee of Per-
    sons and Newborn. Prevention of respiratory syncyt-
    103:1–10.
13. Oldaeus G, Anjou K, Bjorksten B, Chandra,
    ARNE HOST
    Professor of Paediatrics,
    University of Odense, Denmark
    Chair, ESPACI Committee on Hypoallergenic Formulas

Dietary products used in infants for treatment and prevention of food allergy

EDITOR,—The joint statement of the European Society for Paediatric Allergology and Clinical Immunology (ESCAPCI) and the European Society for Paediatric Gastroenter-
ology, Hepatology and Nutrition (ESPghan)1 deserves some comment. Firstly, on the use of soy based formulas for the treatment, as well as for the prevention of food allergy: I was disappointed that no word about this subject appeared in the conclu-
sions of the statement. Many have claimed that the use of soy bean formulas in infancy is an efficient way of preventing food allergic disorders, but more recent prospective
and randomised clinical studies have shown that soy protein is as allergenic as cow’s milk protein.2 As the matter remains controversial,1 I believe that the conclusions should have been that soy based formulas are not recommended for the treatment or prevention of food allergy until more data are available.

The second issue concerns the use of par-
    A1:6]. Second World Congress of Pediatric
    Infectious Diseases:99:206–7. 87
    VeZ
    B1
    C1
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    H1
    I1
    J1
    K1
    L1
    M1
    N1
    O1
    P1
    Q1
    R1
    S1
    T1
    U1
    V1
    W1
    X1
    Y1
    Z1

The editor comments:

In her letter, Dr Carnegie refers to a guidance document reflecting the outcome of a con-

сенсious committee of a number of Australian

clinicians and issued by Abbott Laboratories

Limited. Earlier this year, we received as a submis-

sion for publication such a document, headed

by the names of a number of distinguished

paediatricians and neonatologists. I was puz-

zled because it was addressed from a public rela-

tions company. I contacted all those named on

the letter and the corresponding author was.

I learned that they did not know the paper was to be submitted to a peer reviewed journal.

Consequently, I invited the PR company to

withdraw the submission, which they did. The

paper, itself, was marked as having been

withdrawn, which they did.

HARVEY MARCOVITCH
Editor in Chief

Letters, Book reviews

Health care needs for travellers

EDITOR,—The article recently published by van Cleemput has made a valuable contribu-

tion to the health care needs of travellers and has drawn attention to a very deprived section of

our community.1 However, the assertion that childhood asthma is more common in travellers is

not based on sound evidence. This suggestion was based on a study by Anderson, who reported on

health concerns and needs of traveller families.2 The selection criterion for Anderson’s study was

families with children of less than 5 years of age. The traveller families had a mean of six

children aged 1 to 15 years. The control

1 Chandra RK. Five-year follow-up of high risk

infants with family history of allergy who were

exclusively breast-fed or fed partial whey hydro-

lysat, soy, and conventional cow’s milk formula.

2 Kerner JA. Use of infant formulas in prevent-

ing or postponing atopic manifestations. J Pediatr

3 Cantani M, Liesi M, Salazar-de-Sousa J. How to

assess the history of soy allergy and/or intolerance in children, and clinical use of soy-protein formulas. Pediatr

Allergy Immunol 1997;8:59–74.

1 Chandra RK. Five-year follow-up of high risk

infants with family history of allergy who were

exclusively breast-fed or fed partial whey hydro-

lysat, soy, and conventional cow’s milk formula.

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assess the history of soy allergy and/or intolerance in children, and clinical use of soy-protein formulas. Pediatr

Allergy Immunol 1997;8:59–74.
affluent families had a mean of 1.7 children aged 1 to 3 years, and the control inner city families had a mean of 1.9 children aged 1 to 4 years. Anderson reported that asthma was a concern to 30% of travellers compared with 11% of inner city families and 4.5% of affluent families, using a questionnaire that seemed to tackle parental concerns only, and was not validated for asthma incidence. Yet, van Cleemput extrapolated a high incidence of asthma in travellers’ children from this study, and did not comment on questionnaire validation or the confounding factors of age and transient early wheezing.

We used the ISAAC (International Study of Asthma and Allergies in Childhood) questionnaire to compare the prevalence of asthma in schoolboys, aged 6 to 12 years, from travellers’ families with settled controls.2 The parent reported prevalence of wheezing and related symptoms were all more common in schoolboys from the control group than in traveller schoolboys. The values were significant for wheeze in the last year (31.3% vs 14.8%, OR 5.6, p=0.025), and for doctor diagnosed asthma (25.6% vs 11.1%, OR 2.7, p=0.04). We concluded that the experience of travelling lifestyle may be a protective factor in the development of asthma.

Fits, pyridoxine, and hyperprolinaemia type II

EDITOR,—There are currently two types of measurements that are used to assess vitamin B6 status. These are measurements of vitamin B6 and its metabolites, and activation of vitamin B6 dependent enzymes and associated amino acids. Tryptophan loading test is also used to reveal the subtle defects by measuring serum and red blood cells (functional deficiency). Recommended values are used to assess vitamin B6 and its metabolites, and activation of vitamin B6 dependent enzymes and associated amino acids. Tryptophan loading test is also used to reveal the subtle defects by measuring serum and red blood cells (functional deficiency).


LHRH analogue and growth hormone did not improve the final height of a patient with juvenile hypothyroidism accompanied by precocious puberty

EDITOR,—We report an 11 years 8 months old girl with juvenile hypothyroidism and precocious puberty who failed to respond to thyroxine, growth hormone, and luteinising hormone releasing hormone (LHRH) analogue. The patient was considered to be hypothyroid for about two years before the therapy was started. She had a very low serum thyroxine concentration, a height SD score of −3 SD, and a bone age of 10 years 3 months.

Hypothyroidism was graded as Tanner stage IV of breasts and pubic hair. Her menarche occurred at the age of 10 years 3 months. The enlarged pituitary gland reduced in size with the thyroxine treatment (100 µg/day). In addition to thyroxine, she was treated for 31 months with an LHRH analogue (30 µg/kg, once a month) and growth hormone (0.5 mg/kg/week divided into doses) to avoid the progression of puberty and improve the final height. She reached the final height at the age of 15 years 1 month (~2.8 SD), which was the same as before the treatment (fig 1).

Minamitani et al reported that treatment with LHRH analogue and growth hormone in addition to thyroxine was successful in improving the final height and avoiding pubertal growth of patients with juvenile hypothyroidism in the prepubertal stage.1 Differences between the report of Minamitani et al and our case is that our patient already had the advanced bone age relative to height and the progression of puberty at the start of treatment, to which our failure to improve the final height with the combination therapy might have been ascribed. To improve the final height, we should have increased the dose of LHRH analogue and growth hormone. During the combination therapy, peak serum insulin like growth factor 1 was 710 ng/ml (normal: 370–896 ng/ml), and peak concentrations of LH and FSH were completely suppressed in response to gonadotropin releasing hormone. Although her menstruation was successfully suppressed, bone maturation was not inhibited.

We concluded that patients with juvenile hypothyroidism who are often found to be in progressive pubertal development, tend to be of utmost importance in improving the final height. In Japan, schoolchildren are biannually measured for height and weight. It is therefore strongly urged to educate school nurses to direct their attention to the evaluation of height measurements and also to arrange and conduct paediatric endocrinologists. Although a number of possibilities have been raised for failure in attainment of desired height in the patient, the early medical attention would have been expected to lead to the possible prevention of short stature.

This work was supported by grants from the Ministry of Health and Welfare of Japan, the Ministry of Education, Science, and Culture, the Japan Private School Promotion Foundation, and the Mami Mizutani Foundation.


Intraosseous access in infant resuscitation

EDITOR,—We believe that intraosseous access to the circulation in infant resuscitation is undervalued and therefore under utilised. Intraosseous cannulation is an alternative to the circulation in infant resuscitation and provides a rapid and reliable route for the delivery of fluid boluses to the circulation in infant resuscitation. Intraosseous cannulation can be a technical challenge in collapsed infants. Small veins are prone to damage when fluids are rapidly purged through them. Central venous access is not usually established in the immediate resuscitation period and larger intraosseous...
cannulae (22 and 20 gauge) can be difficult to site in small infants presenting with circulatory failure.

Our simple experiment has shown that fluids can be infused through an intraosseous cannula at a significantly higher rate than that of the intravenous devices. The resistance to flow in situ has not been calculated, but one could reasonably expect the capacitance of the marrow cavity to be greater than that of an infant’s peripheral vein. These factors, in addition to the ease and success of placement of intraosseous over intravenous cannulae, lead us to advocate that greater emphasis is placed on the value of intraosseous cannulation during the early phase of resuscitation in infants.

This is an important issue that should be addressed both locally and nationally, as well as through advanced life support provider courses (APLS/PALS).

ROSS FISHER
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DYLAN PROSSER
Consultant Paediatric Anaesthetist, Royal Belfast Hospital for Sick Children, St Michael’s Hill, Belfast BT2 8BJ, UK

Table 1: Results and calculated infusion time for a bolus in a 5 kg baby

<table>
<thead>
<tr>
<th>Access device</th>
<th>Gauge</th>
<th>Flow rate (ml/min)</th>
<th>Infusion time for 100 ml bolus (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow venflon*</td>
<td>24</td>
<td>35.6</td>
<td>2.81</td>
</tr>
<tr>
<td>Blue venflon*</td>
<td>22</td>
<td>60.6</td>
<td>1.65</td>
</tr>
<tr>
<td>Pink venflon*</td>
<td>20</td>
<td>126.8</td>
<td>0.79</td>
</tr>
<tr>
<td>Green venflon*</td>
<td>18</td>
<td>161.2</td>
<td>0.62</td>
</tr>
<tr>
<td>Intraosseous needle</td>
<td>18</td>
<td>248</td>
<td>0.40</td>
</tr>
</tbody>
</table>

* BOC Ohmeda AB, SE-25106 Helsingborg, Sweden.

EDITOR,—In their retrospective study, Mona-type 1 Natural history of glutaric aciduria courses (APLS/PALS).

This is an important issue that should be addressed both locally and nationally, as well as through advanced life support provider courses (APLS/PALS).

CARLO CAFFARELLI DAVID J AThERTON

Books


The youth of today are not what they were: they are bigger. Rona and Chinn, in their long and meticulous study of the health and growth of some 87,000 children, have documented the continuing trend to increasing height for age in primary school children over a 20 year period. This is generally thought to be a good thing and indicative of ever improving health and nutrition. The trend has been rumoured to be at an end many times, but in fact continues. Similarly, poverty was thought to be at an end in the 1970s when this study had its beginnings, only to be reluctantly rediscovered after the Black report. The two clearly go hand in hand: when there is no more poverty and perfect health and nutrition have been achieved, there will be no further gain in height. The effect of poverty is illustrated in this study, as in many others, by the social class gradient in height. Yet the exact mechanism of the relationship is mysterious as most of the gradient disappears after adjustment for parental height. The authors argue that most of the variation must therefore be genetic, others argue that there has been overadjustment.

The other secular trend observed has been of increasing obesity; a worrying trend in light of the much larger epidemic in adult obesity. But then again all is not what it seems. Mean weight for height is referred to throughout as “obesity”. Yet, as this is the age when children pass through the thinnest phase of their growth, few if any will be actually obese and presumably a proportion were actually underweight. When does less undernutrition become too much overnutrition, and how do we tell? So a paradox: the secular trend to increasing height is good and is due to improved overall nutrition. The parallel trend screen for CF mutations. While it is possible that we may have missed a child in whom the combination of asthma and respiratory symptoms was due to CF, we consider it exceedingly improbable that such omission would have substantially prejudiced our results.

The finding that gastrointestinal symptoms, for most of which there was no simple explanation, are common both in children with atopic eczema and in children with asthma, suggests that these symptoms are a reflection of the patients’ atopic status itself, and undiagnosed CF is unlikely to be a significant contributory factor. Neither do we believe that these symptoms can merely be dismissed as being due to food allergy, any more than one could dismiss either atopic eczema or asthma themselves as being caused exclusively by food allergies. The precise aetiologies of these conditions remain to be clarified.


Natural history of glutaric aciduria type 1

EDITOR,—In their retrospective study, Mona-vare and Naughten (Arch Dis Child 2000;82:67–70) suggest that early intensive management can alter the natural history of glutaric aciduria type 1. However, the pathogenesis of this disorder is poorly understood and just what is responsible for the better outcome is not clear. In several families in which the first child has the classical phenotype, we have noted a marked difference in outcome of siblings without any specific treatment.

Family 1—In this Jordanian family the first child had a severe movement disorder and died. The second has macrocephaly and mild gait disturbance but is attending normal school.

Family 2—This first child of Nigerian and West Indian parents has a severe dyskinetic cerebral palsy. Her sister has minimal symptoms and attends a normal school.

Gastrointestinal symptoms in asthmatic patients

EDITOR,—Caffarelli et al comment on several immunological mechanisms by which gastrointestinal symptoms could occur in asthma. They do not comment on whether they excluded cystic fibrosis (CF). This is relevant as there are an increasing number of mild phenotypes of CF presenting as asthma. CF could be a unifying diagnosis in the “asthmatic” with gastrointestinal symptoms.

The important clinical message is to consider a diagnosis of CF in difficult cases of asthma.

JOHN FURNESS
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to increasing weight for height is bad and is
due to improved overall nutrition.
No dataset can provide all the answers. By
collating their long work and summarising all
their analyses in this well structured and
admirably slim volume, the authors make it
possible for the idle and speculative like
myself to argue with their conclusions. The
range of the work is vast: from heart disease
risk factors and asthma prevalence, to the
prevalence of enuresis and food intolerance. It
may come as no surprise that the last has a
strong inverse relation with level of educa-
tion, but the adverse impact of food exclusion
on height certainly surprised me. No doubt
future generations will dip into this rich data-
set and pick out many more plums to inform
both research and practice. We can be grate-
ful to Rona and Chinn for making it possible.
CHARLOTTE WRIGHT
Honorary Consultant in Community Child Health

Using the Internet in Healthcare. Tyrrell
S. (Pp 168, paperback; £17.95.) Radcliffe
Medical: a Guide to Effective
Searching Katcher BS. (Pp 148,
paperback; £29.) Ashbury Press. ISBN 01
96734 450 6

Good, I thought, as these books dropped
through the letterbox.
The day before I’d been party to a family
receiving an antenatal diagnosis of gastro-
schisis, and the father had commented on
“looking it up on the Internet”. I wanted to
learn more about the condition myself, and
reckoned I’d follow the man’s example.
Using the Internet in Healthcare sounded
an ideal title; disappointingly it wasn’t. It’s
a book about the basics of the Internet, which
isn’t bad, but is presented better in other
books (for example, Internet for dummies). It’s
“medical” legitimacy comes from a
good summary of NHSnet and a crumb of
information about healthcare searches on the
Web. (Embarrassingly, it was MedLine: a guide to
effective searching that containing the nicest
www resources.)

MedLine: a guide to effective searching was
also a let down. It’s beautifully written, starts
with a lovely summary of the history of
MedLine, but annoys with drawn out expla-
nations of Boolean logic and historical access
systems. In explaining PubMed, it doesn’t
even mention the excellent “Clinical queries”
systems. In explaining PubMed, it doesn’t
nations of Boolean logic and historical access


Evidence based care is upon us, whether we
like it or not. There is a multitude of books on
the subject, so how is this one different? This
is the first in the “Harnessing health infor-
mation series”, and summarises how evi-
dence based care has evolved into main-
stream NHS policy. It does appear to achieve
what the series supports to do, as it harnesses
health information on the subject. The reader
is gently guided around the different organi-
sations set up to implement evidence based
care, and the different policies in each of the
countries of the United Kingdom are
described. Many useful resources are
highlighted, and the reader feels that he or she
can make sense of all the jargon in current usage.

There is a brief introduction to the practice
of evidence based care, with an overview of
the types of research, including qualitative
research, and their advantages and disadvan-
tages for answering different sorts of ques-
tions. The book does not set out to duplicate
the many “How to...” books, but, rather,
points the reader in the right direction. There
is a useful chapter on information sources on
the Internet, and a comprehensive chapter on
guidelines, describing most of the arguments
for and against. Again, the reader is continu-
ously pointed in the direction of other useful
information, without it being duplicated in
this book. Patient information is covered in
another chapter, and this is interesting and
thought provoking reading. Audit, and where
it fits into the system, is also included. Finally,
clinical quality and clinical governance are
brought into the picture, and it all makes
sense.
Ruth Roberts is a nurse, and she empha-
sises the importance of multidisciplinary
working. This is an easy book to digest, mak-
ing common sense of what sometimes seems
a complex system. It gives a “warts and all”
description of evidence based care. The
reader is not put off, but, rather, is left with
the feeling, “I could do it.”
This will be a useful resource for managers,
nurses, doctors, and clinical quality coordina-
tors. It will be useful for senior staff with a
good understanding of the health service and
its current requirements, as well as being a
good starting point for more junior staff who
are trying to make sense of white paper
recommendations, and the national organisa-
tions set up to implement those recommen-
dations. It can be read in a couple of hours,
and will not doubt become pre-interview
reading for would be consultants and special-
list registrars.

MAUD MEATES
North Middlesex Hospital

Essential paediatrics. Edited by Hull D,
Johnston DL. (Pp 400, paperback; £24.95.)
958 6

After coming to this country some years ago,
I decided to take up paediatrics. I remember
asking a senior colleague for advice regarding
any textbook that might help with an introduc-
tion to the subject. She gave me a choice, but
recommended that Essential paediatrics, then
in its third edition, would make easy reading.
I must say I found this sound advice. Of
course, as a postgraduate, one had to progress
rapidly on to other textbooks considered the
bibles of paediatrics. Hence, when I was
asked to review the fourth edition, I was
overwhelmed as it brought back memories of
my first few months in paediatrics.
As the editors have noted in their preface,
this book is meant for medical students. I find
that this has been maintained with regard to
the manner in which different subjects have
been handled with easy to understand
language and diagrams. I continue to find the
first chapter, “The ill child”, the most
impressive and compelling to read, and
would not hesitate to recommend this to
postgraduate doctors intending to take up a
first paediatric post. A similar chapter that
needs special mention is that on emotions
and behaviour, which, in a brief but concise
manner, describes children that we meet
daily. It teaches us the importance of careful
history taking, including social and family
histories.
The book has been updated in many areas,
especially in terms of management, in
keeping with an evidence based approach.
The addition of the British Thoracic Society
guidelines on the management of chronic
asthma is commendable. However, I cannot
understand why the importance of the peak
flow meter has been downplayed, unlike the
previous edition which also included a graph
of normal PEFR values related to height.
On the whole, Essential paediatrics can
be described as user friendly, with numerous
relevant line drawings and important infor-
mation in the margin and in highlight boxes.
Interesting and useful x rays have also been
included in this edition.
Yet why does one get the feeling that this
may not be the first choice textbook for many
medical students? One reason is the limited
number of colour photographs compared with
some other books on the market. Another
reason, I would suggest, is the lack of ade-
quate definitions of some of the common
disorders—for example, coeliac disease
diagnosis and ulcerative colitis.
Despite some drawbacks, I find that Essen-
tial paediatrics is invaluable and have no
qualms about recommending it to medical
students as essential reading.

MINI MARGARET NELSON
Staff Paediatrician

Eating disorders: a parents’ guide.
Bryant-Waugh R, Lask B. (Pp 222,
0 14026 371 3

Their children’s eating disorders pose serious
problems for parents. They may seek profes-
sional help, but services in the United
Kingdom are fragmented and under devel-
oped; therefore, any book that is designed
specifically for parents should be welcome.
My clinical experience is that parents
appear bemused and shocked by the realisa-
tion that their daughter or son has an eating
problem. They are often confused and may
be angry or in denial. Parents may turn to the
popular press, in which articles are some-
times sensible, sometimes sensationalist, wor-
rying, or misleading. High profile cases, such
as those of Princess Diana or Lena Zavaroni
tend to dominate.
The authors have obviously recognised the
lack of sensible self help and advice for
parents of younger children and adolescents.
This book, therefore, is timely and fills an
important gap. A lot of the information is

Immediate care of the critically ill child.


Few would disagree that in the past two decades, world leaders in the relatively young specialty of paediatric intensive care have emerged in Australia, Canada, and the United Kingdom. It is a welcome pleasure, therefore, that the exceptional talents of many of the individuals working in these centres have been brought together to create a much needed practical text encompassing the principles and practice of caring for critically ill and injured children.

The major strength of this book is that it takes into account one of the most important aspects of paediatric critical care, namely that the initial management of these children takes place in a wide diversity of settings. For many children ultimately admitted to a paediatric intensive care unit (PICU), the first few hours of care may have the most significant impact on their clinical course and outcome. This book targets the practitioners most likely to be involved in these situations, and provides key information and a problem-based approach that is difficult to achieve in standard texts.

Like most multidisciplinary texts, the bulk of the book is divided into systems, and by and large system disease and failure are addressed separately. This distinction doesn’t always work, and the inevitable repetition and need for cross referencing can be distracting. Some sections seem to assume no prior knowledge of paediatrics, and others appear to be aimed at the experienced paediatrician. In spite of this, there is a reasonable and logical flow to the text, and many extremely useful tables and diagrams. Key learning points and common errors are highlighted in most chapters, and there is a list of useful tips based on the considerable collective experience of the authors. This sort of approach is as close to bedside teaching that you can get in a textbook, and will be appreciated by trainees in particular.

Areas that stand out include the management of fluid and nutritional problems, toxicological and metabolic emergencies, and the diagnostic investigation of children with cardiac and respiratory problems. It is always difficult to do justice to non-clinical topics like the ethical and psychosocial aspects of critical care, but, at least by including them, the emphasis on the whole patient remains intact. Due attention is given to non-accidental injury and the challenges of transporting patients, the latter reflecting modern, increasingly centralised paediatric intensive care.

In a subspecialty defined by rapid intervention and practical procedures, it is especially difficult to strike the appropriate balance between background detail and clinical practice. On the whole, this book accomplishes this very well. It is not a comprehensive reference text for tertiary care paediatric intensivists, but covers first line treatment to optimise the transition from emergency patient to PICU patient. Until recently, this was mainly undertaken by specialist registrars and consultant anaesthetists, but, in the United Kingdom at least, the next generation of consultant paediatricians will increasingly be called upon to manage critically ill children in those crucial first hours. That group, however reluctantly, will particularly benefit from this useful text.

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Abnormal cortical development and epilepsy: from basic to clinical science.


In his chapter in this book entitled “Neuronal migration disorder and epilepsy in infancy”, Vigevano emphasises that brain malformations represent a causal factor in 3–4% of all epilepsies, although this percentage increases to 18–20% in drug resistant epilepsies. With every new generation of MRI scanner, more and more patients with epilepsy are recognised to have a cortical developmental abnormality, and the aetiological significance of these to the development of epilepsy has opened up exciting new fields in the understanding of the pathophysiology of epilepsy and its treatment. This book is a compilation of papers presented at a meeting on epileptogenic cortical developmental abnormalities, organised by the editors. As with books produced in this way there are strengths and weaknesses, with a bias towards specific topics of interest.

The book starts with a short introduction by Frederick Andermann, followed by several chapters on cortical development and animal models. These early chapters are not easy reading but persistence is rewarded by information of direct clinical relevance from the dry basic scientific details—for example, I learnt that work with animal models has shown that pathological changes continue for years after the initial insult, explaining the delay in the development of clinical epilepsy. Furthermore, the progressive maturation of the neurotransmitter pathways could explain why neonatal encephalopathies are often catastrophic, and why children can grow out of their epileptic tendency, even with lenalidome epilepsy.

The later chapters on electroclinical imaging, neuropathological studies, genetics, and surgery are more relevant for the clinician. In this section, several of the authors emphasise the importance of the term “neuronal migration disorders” for all dysplasias, when the disturbance can be of neuronal proliferation or organisation and not always an arrest of neuronal migration. Of particular interest to me were the chapters on neuroradiology of malformations, neuronal migration disorders and epilepsy in infancy. Schizencephaly: clinical, radiological and genetic findings, and periventricular nodular heterotopia, especially the genetic implications of recognising these various malformations. I also enjoyed Guerrini’s excellent chapter on the development of polymicrogyria. As in his other publications, he points out that polymicrogyria is the only cortical developmental abnormality which can produce ESES with eventual spontaneous remission, and when this pathology is identified on neuroimaging, surgery should be avoided. This leads us to the two chapters on the problems of resective surgery in focal developmental abnormalities and epilepsy; the first by the Montreal group and the second outlining the Italian/French experience. Both emphasise the specific difficulties of deciding the demarcation of surgical resection in these patients. I was particularly interested in the approach of Munari et al to two step surgery, reoperating with more invasive electrocorticography if the seizures do not stop with lesionectomy alone. While acknowledging that cortical dysplasia is often epileptogenic, Munari et al state that, in practice, the epileptogenic zone is often wider than the MRI limits of the lesion, suggesting that the adjacent cortex is also epileptogenic or that microscopic pathology extends further than that seen on MRI images.

The book is a useful addition to the literature on cortical dysplasias. It does not aim to be a comprehensive review and the reader would need considerable prior knowledge of the subject to find the book useful.

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