Use of cyclosporin A as a steroid sparing agent in cystic fibrosis

EDITOR,—In cystic fibrosis (CF) chronic respiratory infection is countered by an intense inflammatory reaction. Systemic steroids have been shown to improve lung function and reduce morbidity in patients with CF and reduce markers of chronic inflammation; however, there are significant side effects associated with their long-term use. Low dose cyclosporin A (CyA) has been shown to be effective in the treatment of inflammatory and autoimmune diseases, corticosteroid dependent chronic severe asthma in adults, and refractory childhood asthma. We report six paediatric CF patients where CyA had been used as a steroid sparing agent. These patients were on treatment with high dose inhaled or nebulised steroids prior to the commencement of CyA, and repeated attempts at reducing the steroid dose were unsuccessful. All patients exhibited steroid related complications including Cushionoid features, growth suppression, impaired glucose tolerance, hypertension, osteoporosis, and bone fractures. The dosage of CyA was adjusted to maintain whole blood trough levels between 100 and 150 ng/ml, using CyA doses ranging from 2 to 37 mg/kg/day.

In the four patients who benefited from CyA therapy the mean steroid dose decreased from 0.86 mg/kg/day in the one month prior to commencement of CyA to 0.30 mg/kg/day six months later and 0.25 mg/kg/day 12 months later. These patients were able to discontinue oral steroids within 18 months of commencement of CyA. Two patients did not show a reduction in mean steroid dosage, one of which underwent a successful heart-lung transplantation.

In the four patients who responded to CyA, lung function was maintained or improved, as were Chirrip-Norman chest x ray scores. Height velocity was also improved. Three patients did develop transient renal impairment, of whom only one required discontinue of CyA. This was dose related and reversible but is infrequent with lower dose regimens used for anti-inflammatory therapy. Other side effects due to CyA were minimal, including mild hypertrichosis and gingival hyperplasia. There was no evidence of hypertension, hepatotoxicity, or neurotoxicity. The side effect profile of CyA is no more severe than for other immunosuppressive agents.

It is evident that CyA is a powerful but potentially toxic therapeutic agent and its use should be balanced against the risks of the disease and the long term use of steroids. These results suggest that CyA can be beneficial as a steroid sparing agent in CF patients; these data may be of help to the clinician in comparable clinical circumstances.

G K BHAL S A MAGUIRE 1 M BOWLER

Letters to the editor

Survey of criteria used to diagnose allergic bronchopulmonary aspergillosis in cystic fibrosis

EDITOR,—Allergic bronchopulmonary aspergillosis (ABPA) creates a difficult diagnostic and management problem in patients with cystic fibrosis (CF). The six major diagnostic criteria for ABPA were adapted from asthma guidelines. Retrospective studies report significant variability in prevalence and the numbers of criteria for diagnosis. This is important as CF databases (UK CF database, European Registry, and the North American CF database) report ABPA frequency either without ascertaining the criteria used, or using limited diagnostic criteria. We have assessed consensus current practice of criteria used by UK CF specialists clinics to support the diagnosis of ABPA and how cases were treated.

This retrospective, descriptive postal questionnaire survey was addressed to senior consultants in the 58 CF specialist clinics identified by the UK CF Trust. A total of 45 replies were received (78%); three were illegible/incomplete. Results are based on 42 replies (72%) from 14 adult clinics (53%), 23 paediatric (55%) clinics, and five (12%) mixed adult/paediatric clinics. Units had a median of 100 patients (interquartile range (IQR) 63 to 160).

Of six ABPA major criteria investigations (table 1), centres routinely tested (at least yearly) a median of four (mode five).

Clinicians were also asked how many of eight factors (table 1) associated with ABPA diagnosis must be present, or were not considered important. It was considered that a median of two factors (IQR 1 to 4) must be present, three preferred to be present (IQR 2 to 5), and one factor was not considered important (IQR 1 to 2.3). Forty per cent of centres considered one or more further factors in addition to those provided.

Thirty per cent of centres would begin treatment without clinical deterioration (62% treat on deterioration). Initial treat-


tment in all centres (100%) was prednisolone: in paediatric patients 1 mg/kg in 21% and 2 mg/kg in 76%; in adults 30 mg/day in 50% (range 20–60 mg/day). In response to failure of steroid treatment 33% would add an anti-fungal agent, 17% would increase steroid dose (17% no experience at steroid failure, 12% other, 21% no reply). Oral antifungals had been used by 69% of respondents, itraconazole in all cases. Paediatric centres were much more likely to use oral antifungals (88% vs 31%, p = 0.004, Mann–Whitney U test). Nebulised antifungals were used by 21%, amphothericin in all cases.

We also asked how many patients would currently be diagnosed as having ABPA in that unit using: (a) criteria stated as “must be present” earlier in the questionnaire; and (b) if major criteria were strictly adhered to. Clinicians considered that they had a median of 5% of patients with ABPA (IQRR 1 to 8), using their own criteria, falling to a median of 0% (IQRR 0 to 3) when all major criteria were strictly adhered to.

This questionnaire shows considerable variability in the criteria used to diagnose ABPA in CF. Prospective reporting of cases with defined criteria will be the only way to reliably identify the true prevalence of ABPA. Database surveys may overestimate the true prevalence.

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Table 1 Replies to questionnaire (% of all units)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Assessed yearly or more</th>
<th>Must be present</th>
<th>Prefer to be present</th>
<th>Not important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspergillus precipitins</td>
<td>83</td>
<td>42</td>
<td>49</td>
<td>10</td>
</tr>
<tr>
<td>Aspergillus specific IgE</td>
<td>52</td>
<td>54</td>
<td>31</td>
<td>15</td>
</tr>
<tr>
<td>CXR infiltrates</td>
<td>95</td>
<td>38</td>
<td>41</td>
<td>17</td>
</tr>
<tr>
<td>Blood eosinophilia (&gt;500/mm³)</td>
<td>83</td>
<td>24</td>
<td>56</td>
<td>20</td>
</tr>
<tr>
<td>Aspergillus fumigatus skin test</td>
<td>5</td>
<td>11</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>Total serum IgE (&gt;1000 ng/ml)</td>
<td>79</td>
<td>45</td>
<td>45</td>
<td>10</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>85</td>
<td>45</td>
<td>45</td>
<td>10</td>
</tr>
<tr>
<td>Wheeze/cough</td>
<td>68</td>
<td>46</td>
<td>39</td>
<td>15</td>
</tr>
</tbody>
</table>

*Six major criteria investigations.

S A MAGUIRE

1 M BOWLER

References

Subnormal growth in children with Helicobacter pylori infection

EDITOR,—We read with interest the study by Choe and colleagues1 in which they investigated the effect of Helicobacter pylori infection and iron deficiency anaemia on growth, especially in pubescent children. In this study, height values were found to be below the 25th centile in 18 of 63 (28.6%) H pylori positive children. The prevalence rate of H pylori infection was 15.5% in children without iron deficiency anaemia and 31.3% in those with iron deficiency anaemia (p = 0.022). They also revealed that the mean height of subjects who had both H pylori infection and iron deficiency anaemia decreased significantly. They concluded that H pylori infection accompanied by iron deficiency anaemia,
rather than H pylori infection alone, might delay puberal growth. We investigated the frequency of diminished growth in 30 H pylori positive children (21 girls and 9 boys) diagnosed by serology and histology. The mean age was 11.5 (2.0) years (range 8–15). We found 11 (36.7%) H pylori positive patients with height values below the 25th centile. Anaemia was determined in none of the patients. Mean haemoglobin concentration was 130 (5) g/l. H pylori infection is a chronic persistent infection, leading to diminished growth. Chronic gastric inflammation, dyspepsia, decreased nutritional intake, and malnutrition may lead to diminished growth. We suggest that the development of short stature in H pylori positive patients may be due solely to H pylori infection itself, and is not related to iron deficiency anaemia.

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Growth monitoring

EDITOR,—Garner and colleagues recently presented a much needed review of growth monitoring.1 This is a component of primary health care on which so much finance and health workers’ time is being expended. No doubt this review will stimulate more necessary trials.

However, they did not touch on one important aspect of growth monitoring—that is, whether health workers using growth charts comprehend the weight for age curve. Popp (1896–1980) considered the line graph to be one of the more difficult subjects to teach. Graphic representation of numbers is not taught in primary schools in developing countries and communities with knowledge of primary education suggest that primary school teachers in these countries would not be able to teach it. Experience with post-graduate doctors in the 1970s suggested that a proportion could not complete a weight monitoring section of their training in this subject. The toiletting record constitutes a starting point, a toiletting record constitutes an important aspect of growth monitoring—that is, whether health workers using growth monitoring—or family participation in community development. Tropical Doctor 1999;29:23–7.

Detecting outbreaks of E coli O157 infection in nurseries

EDITOR,—In their report of a serious outbreak of E coli O157 in a nursery in North Wales, Al-Jader and colleagues recommend that more than one child with more than one bowel motion in a nursery should trigger action including “informing and seeking the advice of public health agencies”.1 Using data on healthy children’s toiletting habits in the paper we have calculated the additional work that would be generated for the Public Health Department in the district where the outbreak occurred if this policy was implemented.1

Of 19 well children on the ground floor of the nursery, six had more than one bowel motion on at least one of the half day sessions attended during the surveillance period.2

Well children attending the nursery for six days during the period, given an approximate total number of sessions attended of 228 (19+6+2). The probability of a well child having more than one bowel motion during any half day session was therefore about 0.026 (6/228). There are 385 nursery and playgroups in North Wales, with an average of 23 children per nursery.3 In an average nursery the probability that two or more well children would have more than one bowel motion in a session on any one day is 0.12, equivalent to a false alarm every eight days.

Therefore, if the suggested policy was implemented, and incidents were reported to the Public Health Department, this would result in approximately 46 inappropriate calls per day (0.12×385)—that is, 230 per week. Even if the normal background rate was ten times lower than that seen among well children during this outbreak, this would still result in just over three calls a week to the department reporting false alarms. The proposed “early warning system” is therefore almost unworkable, and the claim that it could have prevented 10–12 of the 31 cases in the outbreak needs to be reviewed.

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Dr Salmon comments:

Children who attend out of home care are at increased risk for infectious diseases of which gastrointestinal tract infections are among the most common.1 Numbered among these are VT+ E coli O157 infections which, as this outbreak showed, can cause severe disease. The challenge is to identify disease in time.

In this outbreak, given that the first two cases attended the nursery for two days after the onset of their disease on 21 August and the first case from the nursery was not reported until 1 September by which time 13 further symptomatic cases had occurred, our claim that 10–12 cases could have been prevented by taking further action, at this point, is straightforward. The toiletting record might have constituted a signal for such action. We list a range of possible responses, particularly when the bowel motion is loose or offensive (inquiring about symptoms at home, suggesting a visit to the family doctor, arranging a faecal sample, and informing and seeking the advice of public health agencies). We were aware of the issue of specificity and did not suggest that all these activities should necessarily occur on every occasion that more than one child with more bowel motion was recorded. Most agree that faecal sampling needs, generally, to be encouraged.2 However, to combine the activities into a workable algorithm was beyond the scope of the report. Constructing an algorithm is worth attempting, however, since, as a starting point, a toiletting record constitutes a straightforward record used in a number of care settings.

R L SALMON
Consultant Epidemiologist

1 Holmes SJ, Marrow AL, Pickerling LC. Child care practices; offer of food and drink, the epidemiology of infectious diseases and antibiotic resistance. Epidemiol Infect 1996;110:10–28.

Meningococcal disease due to W135: fresh public health concerns

EDITOR,—The paediatric intensive care unit at St Mary’s Hospital in London admits more than 100 cases of meningococcal disease each year from over 50 different hospitals in the south east of England. Since 1992, the unit has treated over 650 patients with the disease, but had not treated a single case of serogroup W135 meningococcal infection until April 2000. We would like to report four children treated at our unit for meningococcal disease due to serogroup W135, type 2A, subtype P1.2, P1.5, within a one month period from April 2000. They had been vaccinated recently with meningococcal serogroup C conjugated vaccine, and had all been
in contact with travellers returning from Mecca. The clinical features of these cases are outlined in Table 1.

Table 1 Clinical presentation, severity and outcome

<table>
<thead>
<tr>
<th>Case</th>
<th>Age (months)</th>
<th>Sex</th>
<th>Contact with travellers</th>
<th>Presentation</th>
<th>Resuscitation fluid*</th>
<th>Maximum inotropes</th>
<th>Mechanical ventilation (days)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10m/F</td>
<td>Grandmother</td>
<td>Petechiae, septicaemia</td>
<td>80 ml/kg fluid</td>
<td>0</td>
<td>No inotropes</td>
<td>2 Discharged</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>27m/M</td>
<td>Father</td>
<td>Purpura fulminans, septicaemia</td>
<td>350 ml/kg fluid</td>
<td>2.2 ucg/kg/min</td>
<td>No fluid</td>
<td>11 Peripheral gangrene</td>
<td>Neurological sequelae</td>
</tr>
<tr>
<td>3</td>
<td>4m/F</td>
<td>6 family members</td>
<td>Meningitis, seizures, no rash</td>
<td>90 ml/kg fluid</td>
<td>0</td>
<td>No fluid</td>
<td>0 Discharged</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>19m/F</td>
<td>2 Aunts</td>
<td>Purpura, septicaemia</td>
<td>90 ml/kg fluid</td>
<td>0</td>
<td>10 ucg/kg/min</td>
<td>2 Discharged</td>
<td></td>
</tr>
</tbody>
</table>

*Total resuscitation fluid required in first 24 hours

The clinical features of these cases are outlined in Table 1.


Prevention and treatment of cow’s milk allergy

EDITOR—Divergences in existing guidelines on the prevention and treatment of cow’s milk allergy (CMA) in infants7 seemed settled when a joint statement by the committees of ESPACI/ESPGHAN appeared in ADC. However, we take exception to some of the assumptions, which have been left open to challenge from both nutritional and allergological points of view. Our concern is that lactose free diets from birth may cause neurological problems in healthy children.

Galactose is a functionally important component of myelin galactolipids, but it is unclear whether a lactose free diet plays a role in the clinical neurological abnormalities of children with galactosaemia. However, lactose is essential for patients with UDP-galactose-4-epimerase deficiency. Though rare, this disorder should be considered in the evaluation of the risk:benefit ratio and the costs of planning a prevention strategy for which the benefits are still unclear. In this context, issues of colonic ecology and malabsorption take second place. The use of screening tests for errors of lactose metabolism as interpreted in the statement may also be misleading. The claim that “feeding lactose-free diets from birth . . . will cause false negative results in most neonatal screening tests for galactosaemia” overlooks the fact that these tests do not establish blood galactose levels but the presence/deficiency of the enzymes responsible for galactosaemia. The assertion “. . . formulas based on intact soy protein isolates are not recommended for the initial treatment of food allergy in infants, although a proportion of infants with cow’s milk protein allergy tolerate soy formula” is based on the ESPGAN Committee on nutrition and on the AAP recommendations. While the former concerns itself with clinical gastrointestinal manifestations, the latter recommendations state in conclusion (point 8): “Most infants with documented IgE-mediated allergy to cow milk protein will do well on isolated soy protein-based formula”. Initial treatment for allergic disease is avoidance of the incriminated allergen. Soy formula has been recommended in treatment of CMA on grounds of efficacy, adequate nutrient intake, and cost. In the absence of prospective studies comparing the allergenicity of cow’s milk hydrolysates against soy formulas in children with CMA, the rationale to alter this indication appears to be lacking.

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Pyridoxine dependent and pyridoxine responsive seizures

EDITOR—Seizures in infancy and early childhood responsive to pyridoxine are well recognised but rare. Baxter has recently observed that almost a third of neonatal cases of pyridoxine dependency present with apparent birth asphyxia and/or suspected hypoxic-ischaemic encephalopathy, and recommended that, because of the high proportion of atypical cases, all children with early onset (younger than 3 years old) intratable seizures should receive a trial of pyridoxine whatever the suspected cause. Following this recommendation can be of remarkable benefit.

We report a case of a Caucasian boy, born at term who presented at delivery in a state of unexpected collapse requiring intubation and resuscitation. He developed tonic seizures within hours of birth and was treated with phenobarbitone, phenytoin, and clonazepam. At 48 hours, an EEG showed a burst

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Letters, Book reviews, Corrections
suppression pattern. There was biochemical evidence of multi-organ damage. He was extubated on day 5 and discharged on day 16 on phenobarbital. He continued to have frequent myoclonic seizures. At 6 months, phenobarbital was replaced by sodium valproate with some initial benefit. By 7 months, he was having focal motor seizures affecting his right arm up to 40 times a day and additional atypical absences and tonic seizures. He also showed signs of an emerging spastic quadraparesis. EEG showed right sided spike and wave discharge with a frontal emphasis. At 8 months a trial of oral pyridoxine (30 mg/kg/day) was given. No seizures have been observed hence pyridoxine was started. He is now 16 months old. He is maintained on pyridoxine 15 mg/kg/day; valproate has been discontinued. The EEG no longer shows spike and wave activity. The signs of spastic quadraparesis remain.

We have reviewed the notes of children attending The David Lewis Centre, a residential school for children with severe epilepsy. Children at The David Lewis Centre attend from all over the UK and their early epilepsy management has been undertaken at many different centres. 31 children with intractable cryptogenic epilepsies, which started before they were 3 years old, were identified (dates of birth 1979–1999; scores or simple oximetry are limited in their ability to identify obstructive sleep apnoea (OSA), as they are able to identify significant OSA but not mild to moderate cases. 

Data is now accumulating that even mild OSA may be associated with significant neurocognitive morbidity in children. 

Full polysomnography is the current gold standard. The Visslab has not been satisfactorily validated against full polysomnography, and the results presented in van Someren and colleague’s paper showed a discrepancy in two of 10 simultaneous recordings (a 20% error rate) with important differences in mean oxygen saturation between the two systems (95% v 93%). It is true that full polysomnography may not be required in all children for the diagnosis of OSA, but this process should be one of working down from a gold standard rather than edging up towards it. The arguments used by van Someren and colleagues against the use of full polysomnography are weak. Children in dedicated sleep areas tolerate full polysomnography well: in the 54 full polysomnographic OSA studies performed in children in this unit over 2 years, sleep efficiency was a mean of 90% (SD 8%), which includes children with frequent wakening as a result of their OSA!

In recent years, centres in both North America and Australia have dedicated significant funding to paediatric sleep laboratories and the appropriate training of both nursing and medical staff towards specific specialist training criteria; the UK sadly lacks such support. With the exception of one paediatric unit (concentrating on sleep in rare disorders) sleep related research in the UK is linked to adult centres. UK paediatrics needs a sleep medicine wake up call, so that standards can be set from gold.

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Share prices of dot.com companies have plummeted because, we are told, there are too many players in the market place for them all to be viable. The dot.com bubble has burst. This may also be true of paediatric textbooks. Such thoughts might trouble the authors and publisher of the fourth edition of the ABC of One to Seven, were it not for the pictures it contains. Is there really demand for another general paperback text covering well trodden ground, with predictable text and liberal use of blue boxes to convey the impression that there is a lot more colour than is really the case? Perhaps not, but for those pictures. This book isn’t cheap, maybe that’s because of the pictures. In short, this book is worth the investment for the pictures alone.

Medical students like to console themselves with thick books because many of us still hold fast to the well-known belief that you can learn a lot about a subject by buying a “good book”, even without opening it. Perhaps the same is true of GPs; fat books with hardback covers are much more impressive shelf-fillers than paperbacks with pictures.

But what about when the time comes to learn paediatrics? We need something on which to hang the facts of any textbook, and we all know the daunting effect of long paragraphs of plain text on page after page. This is where pictures and diagrams come into their own, and the ABC of One to Seven has them in spades. They are almost always helpful and relevant—if not adding to the explanation, then proving the useful peg on which to hang a particular fact. Captions though, are few and far between. The reader can sometimes be left confused as to the purpose of a particular illustration. Several of the pictures appear two or three times and others are decidedly outdated. Ambulances and toys appear two or three times and others are barely mentioned. Several of the pictures are much more impressive shelf-fillers than is really the case? Perhaps not, but for those pictures. This book isn’t cheap, maybe that’s because of the pictures. In short, this book is worth the investment for the pictures alone.

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Medical students like to console themselves with thick books because many of us still hold fast to the well-known belief that you can learn a lot about a subject by buying a “good book”, even without opening it. Perhaps the same is true of GPs; fat books with hardback covers are much more impressive shelf-fillers than paperbacks with pictures.

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