LETTERS TO THE EDITOR

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Sweat chloride and conductivity 1

EDITOR,—As a principal author of the sweat testing document published by National Committee for Clinical Laboratory Standards (NCCLS) and consultant to the Cystic Fibrosis Foundation (CFF) (USA), I write to address an inaccuracy in the article by Heeley et al. 1 The authors misrepresent the NCCLS document on the role of conductivity analysis. Nowhere does the NCCLS document address an inaccuracy in the article by Heeley et al. 1 It goes on to state that the CFF has approved evaporation error. The NCCLS document states, “The diagnostic equivalence of indirect and direct sweat electrolyte measurement should be regarded as effective as chloride measurement for the diagnosis of CF.” 2

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Sweat chloride and conductivity 2

EDITOR,—As the authors point out, chloride provides greater discrimination than sweat sodium—greater discrimination than sweat sodium—than conductivity along with a bias plot of the data so that the reader could assess the correlation. Most studies need to be published comparing conductivity with chloride, particularly in patients with results in the equivocal range, before the conclusion can be made that sweat conductivity is as effective as chloride measurement for the diagnosis of CF.

ANTHONY HEELEY
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Dr Heeley et al respond

EDITOR,—As the principal author of the NCCLS guideline on sweat testing methodology, Dr LeGrys should be better informed of its content. It includes the clear statement that when sweat test results are obtained by conductivity measurement “the patient should be referred for quantitative sweat electrolyte testing”. In our paper we refer to this statement as implying that sweat conductivity measurement should be regarded as “unreliable for diagnostic purposes”. This surely cannot be conceived as misrepresenting the NCCLS position, as claimed by Dr LeGrys. Although the NCCLS does, by reference, attribute this advice to Cystic Fibrosis Foundation (CFF) (USA) policy, by including it in their guideline without comment or qualification, the NCCLS authors are actively promoting it.

The medical politics of the USA do not concern us, but rather the question as to whether there is any scientific evidence underpinning this advice which the NCCLS uphold. The result of our study suggests there is none.

Dr LeGrys quotes research findings which support the conclusion that sweat conductivity measurement is appropriate only for initial screening purposes. We contend that there is no data presented in this otherwise excellent paper which provide scientific justification for that conclusion.

Dr LeGrys is of the opinion that the conclusion we draw from our own study should have been supported by appropriate linear regression and bias plots of the data. The Arch Dis Child’s professional statistical adviser reviewing our manuscript, which included such data analysis, thought otherwise and requested us to remove it.

Dr LeGrys should now be pleading for more studies to be carried out to resolve the issue of the diagnostic equivalence of indirect and direct sweat electrolyte measurement, focusing on patients who produce results which are equivocal. Considering the relative rarity of such patients in general paediatric practice, if the problem revolves around these cases, why did the NCCLS guideline state this in the first place? In reality, the final diagnosis of cystic fibrosis in these cases is likely to be resolved by the results of investigations other than the sweat test.

MARY HEELEY
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Dr LeGrys refers to a paper published in ADC or FeNi...
The inclusion criteria for Sharief and colleagues’ study was a clinical suspicion of urinary tract infection, when urine cultures were sent and dipstick testing was done. We found that urinary tract infection could easily be missed if urine culture is used, whether if nitrites or leukocyte esterase are positive. Surprisingly, the results of both our study and theirs are similar: sensitivity was 34.4% vs 20.0% and specificity was 90.7% vs 99.2% in our study and Sharief and colleagues’ study, respectively. Negative predictive value was 92.4% in our study and 96.7% in Sharief’s study. Only the interpretation of the results is different.

A test with such a low sensitivity cannot be recommended as a screening test to exclude urinary tract infection. Urinary tract infection may result in irreversible renal damage in infants and therefore most care should be given to the detection of this infection in this age group. Unfortunately, there is a group where sensitivity of dipstick testing is the lowest (20%). I agree with Sharief and colleagues’ study that because of its high negative predictive value, dipstick testing may have some role as a screening test of trunnt infections in situations where the incidence is very low. Positive nitrites have a high specificity for urinary tract infections, which was the basis of our suggestion that if nitrites are positive, especially in a febrile infant, empirical treatment with antibiotics may be considered until the result of urine culture is obtained. However, it should not be the whole criterion for diagnosis of this infection.

should repeat lumbar punctures be routinely done in neonates with bacterial meningitis? Results of a survey into clinical practice

EDITOR,—Neonatal meningitis remains a very important cause of morbidity and mortality, with 30% death or handicap rate reported in a recent study. In common with other clinical situations, the evidence base for some of the management recommendations for good clinical practice is hard to find. One particular aspect of the management of neonatal bacterial meningitis is whether or not a repeat lumbar puncture should be undertaken routinely. Several standard textbooks of neonatology recommend repeating the lumbar puncture routinely in the course of neonatal bacterial meningitis, in order to ensure that “meningitis” continues to improve. This recommendation is based on past practice, and current evidence in favour or against repeating the lumbar puncture in neonatal bacterial meningitis is unclear.

However, we have observed that day to day clinical practice appears to have changed and fewer repeat lumbar punctures are being done. To investigate this we performed a simple questionnaire survey across the north...
EDITOR,—Dr Elliman is noted for his careful analysis of evidence on this issue and other related issues. His summary of Swedish statistics since 1983 is extremely informative. It shows that the rate of non-abusive or customary physical punishment is not so careful in his recent analysis of physical punishment.1

The American Academy of Pediatrics’s co-sponsored scientific consensus conference on corporal punishment used a more scientific approach than the Elliman-Lynch summary. Firstly, it carefully defined spanking as a subset of corporal punishment. Secondly, it incorporated a range of scientifically validated perspectives into summary statements, that were more balanced than the Elliman-Lynch perspective. Third, it solicited the first systematic review of child outcomes of non-abusive or customary physical punishment by parents,1 which was recently updated.2

Both reviews concluded that non-abusive smacking had consistently beneficial child outcomes in the most causally conclusive studies—for example, randomised trials. Both non-compliance and fighting decreased in 2–6 year olds after non-abusive smacking was used to back up milder disciplinary tactics, such as reasoning or time out. Causal evidence of detrimental effects of customary physical punishment was less conclusive and limited to overly frequent smacking—for example, three times weekly for 6–9 year olds. Head-to-head comparisons, the effects of non-abusive or customary smacking rarely compared unfavourably with any disciplinary alternative, whereas its effects were significantly better than six alternative disciplinary tactics, mostly in 2–6 year olds.

My updated review considered all 92 studies included in the unpublished 1999 Ger-shoff review cited by Elliman and Lynch. Most (76) of her studies were excluded from my review for reasons that Elliman would use to discount vaccination studies—for example, inappropriate measures, cross sectional designs. Ellison and Lynch also presented a one sided summary of Swedish statistics since their 1979 smacking ban. Additional information on this issue and other related issues can be found at http://people.biola.edu/faculty/paulp/. The issues are complex, requiring the same careful analysis given to concerns about vaccination.


Oral steroids and inflammatory markers in asthma

EDITOR,—We thank Dr Grigg for his interest in our work.1 We agree that the asthma attacks may have resolved spontaneously in some cases, which was precisely why we stated that the markers fell in association with steroid therapy, and not necessarily causality. Nevertheless, the statistical analysis suggests that the chances this occurred at random are extremely low.

We agree that corticosteroids do not inhibit, except at very high concentrations, degradation of the eosinophils induced by incubation with opsonised particles, such as Sepharose beads in vitro.2 However, there is overwhelming evidence that cytokines such as IL-5 prime eosinophils for increased release of granule proteins in this situation,3,4 and that they inhibit cytokine-mediated prolongation of eosinophil survival.5 These observations, coupled with the abundant evidence that corticosteroids reduce the expression of eosinophil-active cytokines, such as IL-5, provide a convincing chain of evidence linking the clinical use of corticosteroids with reduced release of eosinophil granule proteins in vivo.

With regard to the controls in this study the ratio of atopic to non-atopic asthmatics was 4:1 and of atopic to non-atopic controls was 3:1. These differences are not significant by chi-squared testing. Whilst we agree that more controls might have strengthened our conclusions, nonetheless the evidence of suppressed inflammation and that of an apparent clinically adequate course of prednisolone, as shown by the elevated levels of IL-5 and sCD25, remains strong.

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West of England to determine the opinion of currently practising/trainee paediatricians and neonatologists. Table 1 shows the results of the survey.

The response rate of 65% is a representative response for this type of survey. There was a good mix of experience—58% consultants and 42% trainees in paediatrics/neonatology; 47% had more than 10 years neonatal experience (table 2). Many textbooks reflect past practices, especially when there is little new published evidence to support a change, yet in some circumstances day to day clinical practice is quite different from that promulgated in the standard texts. In an era of demand for evidence based practice and an ever increasing level of litigation it is clearly important that current practice based on experience is reflected appropriately. This study shows that there is a wide held and practised view that routinely repeating lumbar punctures in neonates with bacterial meningitis is not appropriate and that a selective approach to repeating the lumbar puncture based on the clinical situation is the preferred option. This opinion was reflected by both those with long experience and in the teaching hospitals as well as by those practising in district general hospitals and trainees in paediatrics/neonatology. A national clinical survey of the opinion for infants with meningitis under different management practices should be carried out.

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Lo, district general hospital; LP, lumbar puncture.

Table 2 Breakdown of those who responded

<table>
<thead>
<tr>
<th>Routinely repeat LP</th>
<th>Do not routinely repeat LP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registrars</td>
<td>Consultants</td>
</tr>
<tr>
<td>Routine</td>
<td>3.6%</td>
</tr>
<tr>
<td>Routine</td>
<td>38.5%</td>
</tr>
</tbody>
</table>

Table 1 Results of the questionnaire survey

Question: Do you routinely repeat LP in proven neonatal meningitis?

172 (100%) surveys posted
112 (63%) responded
3 (1.5%) were invalid (incompletely filled)

Answer: YES, 20 (18%) do routinely repeat LP because: It helps in deciding duration of treatment—14 (70%) It reassures that infant is improving—10 (50%) It is recommended in textbooks—9 (45%)

Answer: NO, 89 (82%) do not routinely repeat LP and will only repeat if clinically indicated, because: It will not help in deciding the duration of therapy—63 (70%) Clinical improvement is more important—61 (68%) It is unnecessary trauma—35 (39%)

It is unnecessary trauma—35 (39%)
It will not help in deciding the duration of therapy—63 (70%)
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It is recommended in textbooks—9 (45%)
It is unnecessary trauma—35 (39%)
It will not help in deciding the duration of therapy—63 (70%)
Clinical improvement is more important—61 (68%)
It is unnecessary trauma—35 (39%)

LP, lumbar puncture.
Insufficient to allow precision. In addition, to be discerned are in themselves usually understood. The problem is that the signs available in the early newborn period is easily under- and prognosticate from neurological signs in the nervous system. The aspiration to localise the substantial risk of injury to the immature newborn has carried with it a recognition of the importance of the behaviour state of the baby, as well as the more detailed neurological items has evolved.

A second problem in this area, particularly in relation to research studies, has been the development of a systematic newborn neurological examination which is reliable and repeatable. This has been the subject of the two editions of this work. The first, published in 1981, gave a detailed, easily understood and applied system for the neonatal neurological examination. The current edition brings that work up to date. New material is presented, refinement of the scheme has occurred, and the examination is described. Items which were less discriminatory of pathology from the 1981 version have been withdrawn and, following the work of Prechtl, more emphasis is placed on the analysis of general movements. There is a further post neonatal to two year old infant neurological examination proforma presented briefly at the end of the text.

The text is essentially a manual on the application of this neurological examination scheme. It is easy to follow and the segments of the examination are presented clearly with excellent photographs and line drawings of each manoeuvre. There is also a useful addendum (“cautionary tales”) to each section of the examination, giving guidance on possible pitfalls and sources of error. There is a lot of very useful information on the variations in findings in term and preterm infants, and particularly the changes in the neurological features of preterm infants as they grow towards term. There follows a section on the development of an optimality score from the observed items of the assessment. This section deals with the results of a survey of 224 normal term infants. In this study each item of the scheme was plotted, and centile values (and thereby optimality scores) were computed. This provides quantification of the assessment, a sense of the range of findings to be expected, and can be useful in correlating lesions observed on neuro-imaging with clinical findings. Chapter six deals with the scheme in relation to findings in infants with recognised brain lesions.

The book is not designed to be a text of neonatal neurology and readers looking for discussion of neurological disease states will be disappointed. As a description of a comprehensive and easily applied system of neonatal neurological examination the new edition succeeds admirably.

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