LETTERS TO THE EDITOR

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

Muslim families: Donating organs and asking for post mortems

EDITOR,—I thank Gatrad and Sheikh for their commentary of important Islamic ethical concepts. It has been my experience that religious and cultural factors are both important when addressing medical issues affecting Muslim families at every level.

Government campaigns encouraging organ donation have not increased organ donation in Muslim communities in the UK. A British collaborative effort led to the issuing of a fatwa (proclamations by an Islamic committee) that allowed Muslims to donate organs and carry donor cards. However, evidence suggests that Muslims may be unaware of Islamic rulings on the organ donation. Muslims that are unsure of the Islamic viewpoint must therefore make judgements in the context of their cultural upbringing. Muslim link workers sensitive and knowledgeable to Islamic rites concerning organ donation can be invaluable in this regard. Doctors should also be encouraged to suggest to grieving Muslim families the possibility of organ donation.

The request for a post mortem examination in a Pakistani child is a difficult task. Family members may dispute the need for a post mortem examination for a number of reasons. Firstly, Islam does not allow them. Secondly, a post mortem will delay burial and Muslims are keen to bury the child as soon as possible. Thirdly, because of the belief in predestination—that is, “it is Allah’s will”; families feel there is no need for post mortem examination. Fourthly, families are annoyed with the fact that the child’s body is going to be “interfered with” Muslims avoid the embalming or cremation of bodies, dead bodies are treated with great respect. A medical approach, sensitive to both cultural and religious factors is vital to a complete and fulfilling interaction between the family and the physician.

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5 Black J. Broaden your mind about death and bereavement in certain ethnic groups in Britain. *BMJ* 1987;295:538.

Pediatric ethics in the Holy Quran

EDITOR,—I read with interest Gatrad and Sheikh’s recent articles. It is quite interesting to find some more references (presented as sura/verse) related to pediatric ethics in the Holy Quran.

On organ transplantation

“Whoever killed a human being… should be looked upon as though he had killed all mankind; and that whoever saved a human life should be regarded as though he had saved all mankind” (5:32). On the basis of this Quranic text, organ transplantation is encountered in many Islamic countries.

On motherhood

According to the Holy Quran, the mothers of infants born after in vitro fertilisation and embryo transfer are the women who give birth, not the women who give ovum: “Their mothers are those only gave birth to them” (58:2).

On termination of pregnancy

According to the Holy Quran, if a mother’s health is treated by continuation of a pregnancy, then termination of pregnancy is allowed. “None should be charged with more than one can bear. A mother should not be allowed to suffer on account of her child, nor should a father on account of his child” (2:233; see also 2:185 and 2:195).

On breast feeding

According to the Holy Quran “The mothers shall give suck to their offspring for two complete years” (2:233). However, “If they both (mother and father) decide on weaning, by mutual consent and after due consultation, there is no blame on them” (2:233). The mother who cannot and is not able to breast feed her infant, can give her baby to a wet nurse to breast feed, after mutual consent between the father and mother: “If you support financially the wet-nurse, there is no blame on you” (2:233).

The father should protect the lactating mother from any conditions which might affect breast feeding, and Islam forces fathers to provide financial support for breast feeding mothers who are divorced: “To provide food and clothing is an obligation of the father” (2:233).

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Medicines for children and gentamicin toxicity

EDITOR,—Recently, we changed our gentamicin dosing regimen (2.5 mg/kg 18 hourly for preterms and 2.5 mg/kg 12 hourly for term infants) as it resulted in too many low peak blood levels. Levels were taken immediately before and 1 hour after the third dose. We changed to the regimen given in Medicines for Children (MFC) shown in table 1.

However, after making this change we noticed a high number of toxic trough and peak levels. We audited this retrospectively by reviewing the blood gentamicin levels taken during the last two months of the previous regimen and the first two months of the Medicines for Children regimen. All the infants were less than 7 days old. The target levels were trough <2 mg/l, peak 5-10 mg/l. We grouped the three preterm groups given in MFC together to make comparisons easier. The results are given in table 2.

As intended, the Medicines for Children regimen produced fewer low peaks than the previous regimen in both term and preterm infants (p<0.001). However this was at the expense of an excess of high troughs in both (p=0.014) and preterm (p=0.004) infants and high peaks in the preterm infants (p=0.03). All probabilities were calculated using Fisher’s exact test.

Table 1 Medicines for Children gentamicin dosing regimen

<table>
<thead>
<tr>
<th>Gestation (weeks)</th>
<th>Dose (mg/kg)</th>
<th>Frequency</th>
<th>Timing of levels*</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 28</td>
<td>4</td>
<td>36 hourly</td>
<td>3rd dose</td>
</tr>
<tr>
<td>28–32</td>
<td>4</td>
<td>24 hourly</td>
<td>3rd dose</td>
</tr>
<tr>
<td>32–38</td>
<td>4</td>
<td>18 hourly</td>
<td>4th dose</td>
</tr>
<tr>
<td>≥38</td>
<td>3.5</td>
<td>12 hourly</td>
<td>4th dose</td>
</tr>
</tbody>
</table>

This regimen is for infants of less than 7 days of age. *Levels were taken immediately before and 1 hour after either the third or fourth dose.

Table 2 Comparison of gentamicin blood levels from previous regimen with those from Medicines for Children regimen

<table>
<thead>
<tr>
<th>Regimen</th>
<th>No of infants</th>
<th>High peaks (%)</th>
<th>Low peaks (%)</th>
<th>High troughs (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous (term)</td>
<td>35</td>
<td>0</td>
<td>11 (31)</td>
<td>11 (20)</td>
</tr>
<tr>
<td>MFC (term)</td>
<td>31</td>
<td>3 (9.7)</td>
<td>0</td>
<td>7 (20)</td>
</tr>
<tr>
<td>Previous (preterm)</td>
<td>21</td>
<td>0</td>
<td>10 (47)</td>
<td>0</td>
</tr>
<tr>
<td>MFC (preterm)</td>
<td>18</td>
<td>5 (28)</td>
<td>0</td>
<td>7 (39)</td>
</tr>
</tbody>
</table>
Eleven high peaks or troughs have been excluded from the final figures because of the presence of renal impairment or dosage errors (3 from the previous regimen, 8 from the MFC regimen). Even with the best dosing regimen, there will always be a number of toxic levels due to impaired excretion or dosage error. In view of this, we have changed our antibiotic policy entirely and now use cefotaxime routinely in place of gentamicin. We have a low incidence of cefotaxime resistance in our unit and appreciate that this may not be an option for everyone. Occasionally we will need to use gentamicin for resistant cases and are interested in hearing from anyone who has a gentamicin regimen with cefotaxime routinely in place of gentamicin. It might, however, be more productive and ultimately of more benefit to a child to find out more about the father's social role in the family. What is his relationship, legal or otherwise to the children? Is he resident or non-resident? What is the nature of his continuing involvement in his children's lives and what are the risks or protective factor he poses of abuse or neglect to the children? For a busy paediatrician taking a medical history it is very often difficult to ask these questions. We still find it easier to ask about a family history of asthma rather than about the possibility of domestic violence or if a child has ever been on the child protection register.

The book raises questions about how much training and support is given to junior staff in this area. How do doctors and nurses in training work with violent or abusive men? How are they helped to cope with the fears they can provoke? How are professionals working with children to engage men in the long-term support of their children?

The majority of parents including fathers are committed to their children. Paediatricians should start from the assumption that it is always helpful to engage with fathers. Careful assessment and better training is needed to identify those fathers where engagement is likely to be counter productive. Services to meet the specific needs of fathers are generally thin on the ground. The book contains useful resources and an association of examples of services, which are available specifically for fathers.

Fathers still remain the invisible parent within paediatric and social care services. This book issues some timely challenges to practitioners in the field. Too often in this area we work from a background of prejudice rather than evidence based medicine. When it comes to fathers, the evidence is thin on the ground and there are gaps for future research.

MARY MATHER
Consultant Community Paediatrician


This book is somewhat depressing from the point of view of a UK paediatric oncologist. Coming from such an outstanding hospital it is, as one would expect, an excellent text for all those who care for children with cancer whether they be family or professionals attempting to explain the complex, clearly and succinctly. However, it highlights the great divide between the best in Britain and the rest of the USA—chronic lack of funding for resources and staff in the UK, coupled with far greater public education and involvement in America. St Jude Research Hospital has no equivalent in the UK: it brings together a vast array of experts from diverse specialities and working with this. These recent ideas, and other models of grief, are described clearly and simply, so they can form a firm theoretical foundation for understanding the feelings and behaviours of families.

Moving from the theory to providing effective practical support for families involves gaining sensitivity and compassion but also skills in listening and communication which can be learnt and developed. The guidelines offered in the second part of the book help us assess our own roles and suggest general principles and practical approaches for supporting families. Themes which families identify themselves and which we can respond to are the need for information, control, and permission to grieve. They also remind us that “listening is more important than talking”, and “being there more important than doing”. Topics which provoke particular anxiety such as working directly with bereaved children, identifying situations where specialist help is needed, suicidal intentions, support for schools, and supervision are all approached thoughtfully and informatively. Finally, the book provides a somewhat overviews of support services, resources and further reading.

This new edition of On the Death of a Child offers clear up to date information and immensely practical advice. We can all benefit from Celia Hindmarsh’s wisdom and experience and hopefully increase our own skills and confidence when we are faced with a child’s death.

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Death is no longer quite the taboo subject that it has been in the past but it is still a difficult topic and one which most people meet only rarely. It is easy to feel uncertain what to do and how to help a family when a child dies. It is impossible to take away their pain and so, as Celia Hindmarch observes, “bereavement work makes everyone feel inadequate and it is always tempting to look for an expert who will do a better job”. Her book sets out to help all those involved in supporting families recognise that each of us can contribute, and give us the skills to do so successfully.

Knowledge enhances confidence in a difficult situation and this is the first way in which the book helps. There is comprehensive epidemiological information about the causes of death in childhood, including stillbirth, acute and chronic illness, accidents, and suicide. The special characteristics and problems of the different situations are highlighted and brought to life by relevant case histories.

Resolution of grief depends on recognising and working with this. These recent ideas, and other models of grief, are described clearly and simply, so they can form a firm theoretical foundation for understanding the feelings and behaviours of families.

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Letters, Book reviews
publicly donated finances enabling it to really tackle the challenges of childhood cancer. Its contribution over the last three decades has been truly immense.

There are those who would say that the size of this text, and the depth of detail enclosed is too much for the average family to digest, for many Americans that simply is not so. It is not just the threat of litigation in America that drives the information giving; it was the same 25 years ago when I worked there and then litigation was a rarity. The thirst for knowledge is part of a genuine desire by families to understand and contribute to their child's care; if we fail in the UK to address that need, we really will go down the line of increasing complaints and legal suits. We simply need to get better at communication and to educate our population audience. The real value of the book is for all the professionals concerned to read, learn how to translate science and complex medical terms in to everyday language and share it with patients and families. The era of “trust me I’m the doctor and know best” is well and truly over.

Not every chapter in this book has fully succeeded and editorial control could have been more strict for some contributions but as a whole it works well and is remarkably cheap. I believe that every UK centre ought to have several copies for staff education, but there will be an advantage in getting copies for children to take home; allow it to keep the book with you through school years, and even if you finish it halfway through the next year, you can refer to it after a gap of several years, and when you read it again you will find that it tells a different story.

One addition is that of a preface devoted to the condition and the real possibility of litigation. The key histological feature in Hirschsprung's disease is aganglionosis of the rectum, the demonstration that peristaltic activity in the colon is influenced by many factors including dietary modifications, oral medication, enemas and suppositories. Conventional techniques such as the antegrade continence enema operation, through clinical aspects of Hirschsprung's disease and innovations in surgical techniques such as primary pull-through and laparoscopic techniques. Long term complications, principally constipation, enterocolitis, and faecal incontinence, are also reviewed. The latter has a highly variable incidence between different surgical units and is influenced by many factors including the timing and type of pull-through surgery, the extent of aganglionosis, methods of assessment and the age at which they are applied, and whether patients are evaluated with or without dietary modifications, oral medication, enemas and suppositories. Conventional techniques may improve and the introduction of new surgical techniques such as the antegrade continence enema offer hope for those with intractable soiling.

This book also reviews recent breakthroughs in the molecular genetics of Hirschsprung's disease. At least three susceptibility genes have been identified: the RET proto-oncogene (chromosome 10), the endothelin-B receptor gene (chromosome 13) and the endothelin-3 gene (chromosome 20). It is estimated that RET mutations account for 50% of familial and 15–20% of sporadic cases of Hirschsprung's disease.

For anyone interested in Hirschsprung's disease, this book provides the most comprehensive and authoritative source available.

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