Current Evidence For Offering Treatment with Antibiotics Exclusively In Meningococcal Exanthems

We publish few “personal practice” papers. Partly, this is because once they have been through peer review they become more impersonal. In February 1999, however, we considered it would help paediatricians (or, more accurately, some of their acutely ill patients) to learn how the St Mary’s Hospital London team handled meningococcal disease (MCD).1 The authors stated: “Meningococcal infection should be suspected in any child who presents with a non-blanching rash as 80% of bacteriologically proved cases will develop purpura or petechiae”. This is a vital aphorism for general practitioners but probably redundant for paediatric SHOs (interns). The dilemma faced by the latter is not when to treat but when it is not reasonable not to treat. The key question is what is the false positive rate for diagnosing MCD in the presence of petechiae in very febrile, febrile, or afebrile ill looking or positive rate for diagnosing MCD in the presence of petechiae. This month we correct the omission (page 172) and strongly encourage readers to accept the authors’ invitation to help in its validation as well as that of the Danish proposal.

A moving story

Some readers may think what follows is an example of moving from the sublime to the ridiculous. But there is nothing ridiculous about the suffering experienced by children with chronic constipation. In their “current topic” piece, Sharif and colleagues from Dublin (page 121) question why British paediatricians, unlike those in the US and Australia, have turned up their noses at liquid paraffin (mineral oil). They review evidence for its efficacy and toxicity and describe their own practice, concluding that it has an established track record. They don’t tell us whether this refers to the need for a quick sprint, passage over numerous hurdles, or if it has staying power. Now, could somebody tell us why constipation appears to have reached endemic proportions in general paediatric practice?

Does OME matter?

Readers will find in this month’s ADC two papers on the medium and long term effects of otitis media with effusion (OME). Butler and MacMillan, from Ontario, pose the question of whether early detection of asymptomatic OME prevents delayed language development (page 96). As this paper went through the peer review process, many of us were intrigued by its use of a “causal analytic pathway” to attempt to answer the question, provoked by the absence of any appropriately pertinent RCT. Therefore, the authors looked at studies on the use of individual tools applied to detect the condition. Disappointingly, but unsurprisingly, they conclude that there is insufficient evidence to support early detection of OME if avoiding language delay is the prime objective.

Bennett and colleagues from Nottingham, England and Dunedin, New Zealand look further ahead (page 91). They look at a cohort born in 1972–3, the members of which have been assessed repeatedly with full otological data to the age of 18 years and other information to 26 years. The outcomes studied do not include speech and language but rather behaviour and academic achievement. The authors conclude that an early history of OME predicts problems rather behaviour and academic achievement. The authors note that there is insufficient evidence to support early detection of OME if avoiding language delay is the prime objective.

The grommet (tympanostomy tube) debate is far from over.

Editor in chief

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