Archives this month

Current Evidence For Offering Treatment with Antibiotics Xclusively 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 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 not ill looking children at different ages. The question has been discussed widely ever since the publication of the keynote paper by McCarthy from Yale, on how to recognise the really ill child.[2]

In December 2000 we published an audit[3] which has provoked a debate continued by a series of letters in this month's *ADC*. Acronyms abound: Riordan and colleagues (page 172) quote the ILL criteria of irritability, lethargy, and low capillary refill, which are sensitive but poorly specific. Brogan (page 173) points out that the criteria also include attention to the total white count and C-reactive protein and, if applied properly, operate as a SnNOUT test (if a test is highly sensitive and negative then the diagnosis is ruled out). Mukherjee (page 172) and Davidson (page 173) draw attention to the need for precise definitions and measurements, the former offering ILLNESS (ILL + neutrophilia/neutropenia + elevated temperature suggests significant sepsis). Jones and colleagues report 31 well, afebrile children with petechiae (whom I am pleased to state they do not refer to as WAPS). None proved to have MCD.

Also in this edition we publish results from a multicentre, prospective Danish study (page 160; also published in Danish in *Ugerskrift for Læger*). The authors propose analysing five clinical variables, the presence of two or more offering a 97% probability of the presence of MCD. The authors call for prospective evaluation of their criteria and caution that it is not sensitive with regard to sepsis with other organisms.

We originally published the contribution from Riordan *et al* as an electronic rapid response and were, regrettably, unable to upload their algorithm for treating children with fever and 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.

1 Pollard AJ, Britto J, Nadel S, *et al*. Emergency management of meningococcal disease. *Arch Dis Child* 1999;**80**:290–6.
2 McCarthy PL, Sharpe MR, Spiesel SZ, *et al*. Observation scales to identify serious illness in febrile children. *Pediatrics* 1982;**70**:802–9.
3 Brogan PA, Raffles A. The management of fever and petechiae: making sense of rash decisions. *Arch Dis Child* 2000;**83**:506–7.

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 with reading ability, verbal IQ, and inattentive and hyperactive behaviour many years later.

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

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