Infantile colic and chiropractic spinal manipulation

Editor,—We congratulate Olafsdottir et al on their article. 
The sum of the evidence on spinal manipulative therapy (SMT) in the treatment of infantile colic now is that there are 3 randomised controlled trials (RCTs) on the subject.

Two RCTs demonstrated a significant positive effect of SMT;1 2 and 1 RCT was unable to demonstrate any treatment effect.3

The reasons for this discrepancy are not known, but Olafsdottir suggest that their findings of no effect of SMT may be due to the blinding of the infants’ mothers. Another equally likely explanation could be that we are witnessing a dose response phenomenon.

In their trial, Olafsdottir used a treatment protocol of a maximum of 3 sessions of SMT, whereas the other 2 RCTs, which found a positive treatment effect, used a treatment protocol relying more on the treating chiropractor’s clinical judgement. This more pragmatic approach resulted in 64% of the infants in one RCT receiving 4 or more sessions of SMT (with a maximum of 7);4 and the majority of infants in the other RCT receiving up to 6 sessions.1

We believe that this dose response problem should be addressed in future trials of SMT for infantile colic.

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Alcopops are not responsible for acute paediatric attendances with alcohol intoxication

Editor,—We were interested to read Dr Robson’s leading article regarding alcohol misuse and the reference to acute alcohol admissions to Alder Hey in Liverpool, UK.1 We too are concerned by the increasing number of these problems that we see in hospital paediatric practice.

We carried out a retrospective case note review of all the children seen in the Paediatric Emergency department in Sunderland between November 1999 and October 2000. One hundred children (57 males and 43 females) were admitted for 106 attendances with acute alcohol intoxication (2 children attended twice and 2 three times). The notes of 97 attendances were available for review. Most children were aged 13 to 15 (77%), range 10–16 years. As might be expected, the majority presented during the weekend (66%) and in the evening or at night (84% between 19:00 and 01:00).

Half had been drinking with friends in a public place, although precise details were not recorded in many cases. Sixty one children (63%) were brought in by emergency ambulance and 48 (49%) were admitted. Thirty (31%) were documented to have been drinking vodka, 21 cider (22%), 12 (12%) beer or lager and 11 (11%) other alcohol. Eight (8%) were a combination of these. The type of alcohol was not recorded in 7 (7%) cases.

In no cases were alcopops thought to be the beverage responsible for the acute attendance, and the beverages consumed are comparable with Alder Hey figures from 1996.2

Alcopops and designer drinks appeal to young people, particularly 14–16 year olds, and there has been criticism that marketing may be aimed at this age group. Consumption of alcopops has been associated with drinking in less controlled environments, heavier drinking, and greater self reported drunkenness.3 However, our data do not suggest that they are a problem in relation to acute intoxication presenting to Accident and Emergency. We support the statement that children will mimic adults in their use and misuse of alcohol, and consider that it is society’s changing attitude to alcohol and not the type of alcohol available that is of concern.

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Other implications of disposable nappies

EDITOR,—Partsch, Aukamp, and Sippell propose that increased testicular temperature in early childhood might affect later spermatogenesis. They suggest that disposable nappies may contribute to this and demonstrate a significant difference between the scrotal skin temperature recorded in infants using disposable nappies and washable cotton nappies. They mention in their introductory paragraph that other environmental factors may be important in the deterioration seen in male reproductive health over recent years, but do not relate any of these factors to disposable nappies.1

There are many concerns about the use of disposable nappies in addition to increasing scrotal temperature that may impact on fertility and general health. The disposable nappy consists of a plastic outer layer, a layer of superabsorbent chemicals and inner liner. Nappies are not subject to government controls or independent testing and disposable nappy manufacturers do not need to disclose the contents.1,2

Recently, concern has been raised about the presence of Tributyl Tin (TBT) in disposable nappies. Greenpeace and Women for the Environment Network have commissioned research which showed that there were significant levels of TBT in many brands of disposable nappy, including those on sale in the UK.3 Ever used is still present in a landfill site. Household waste (800 000 tonnes per year) nappies make up approximately 4% of “disposable” waste. In this country, the presence of Tributyl Tin (TBT) in disposable nappies uses 3.5 times the WHO’s estimated tolerable daily intake. TBT is an environmental pollutant which acts as an oestrogen mimic, and dioxins.4

There are environmentally friendly and safer alternatives to the disposable nappy. Modern washable nappies are very different from the traditional idea of buckets of “terries”. There are now shaped cotton nappies with velcro fastenings, alternatives to nappy pins, breathable covers, and disposable paper inner liners. Concern that the incidence of nappy rash is higher with washable nappies is unfounded—it has been shown that it is the length of contact of urine with the skin that is most important in the development of nappy rash and it may be that an infant in a disposable has more chance of developing nappy rash as they are often changed less frequently than an infant in washable nappies. In addition, there are cost savings both to individuals and organisations using washable nappies, and there have been several successful hospital projects using washable nappies on postnatal wards.5

As paediatricians committed to the health of children, we should be aware of the issues raised by the use of disposable nappies, the alternatives that exist, and sources of information and support for parents who are concerned about ensuring a safe and sustainable future for their children.

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The same data, resulting from a single pilot study were reported in the two above papers. The authors have apologised, explaining that they had not intended to flout accepted academic standards, rather than they wished to bring their findings to the attention of two separate readerships—namely paediatricians and nurses. However, we would not wish compilers of systematic reviews to include these data twice and therefore we give notice of duplicate publication and withdraw the article published in Archives of Disease in Childhood.