LETTERS TO THE EDITOR

Rapid responses

If you have a burning desire to respond to a paper published in ADC or FGN, why not make use of our “rapid response” option?

Log on to our website (www.archdischild.com), find the paper that interests you, click on “full text” and send your response by email by clicking on “submit a response”.

Providing it isn’t libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on “read eLetters” on our homepage.

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

Hypoglycaemia and hypothermia due to nimesulide overdose

Editor—Although toxicity due to chronic administration of nimesulide has been reported, to the best of our knowledge there is no report about poisoning due to a single ingestion. We report a 20 month old boy who accidentally took a high dose of nimesulide; no report about poisoning due to a single ingestion. We report a 20 month old boy who

We advise frequent monitoring of vital signs and being alert for hypoglycaemia and acidosi in managing acute nimesulide overdose.

E YAPAKCI
O UYSAL
H DEMIRBILIK
N OLGA
H OZEN

Department of Pediatrics, Hacettepe University School of Medicine, Hacettepe University, Bisan Dalgarnas, Gucuk Hastanesi, Gastroenteroloji Unitesi, 06100 Ankara, Turkey

e-mail: haorec@hacettepe.edu.tr


Port-A-Cath use in refractory seizure disorders

Editor,—The use of a totally implantable venous access system (Port-A-Cath) in children has become widespread in the last 15 years. We report a series of three children for whom the Port-A-Cath improved manage- ment of their refractory seizures.

Two patients both females with a diagnosis of severe myoclonic epilepsy of infancy and recurrent status epilepticus presented in the first year of life. Both had seizures, which were intractable to multiple anticonvulsants and became refractory to benzodiazepines. Intravenous midazolam was used, and to ease management of status epilepticus a Port-A-Cath was inserted at the age of 16 months in one and 4 years 3 months after insertion in the other. The third patient presented at 4 years with Lennox-Gastaut syndrome. Hospitalisation and being alert for hypoglycaemia and acido- sis is managing acute nimesulide overdose.

Port-A-Cath use in refractory seizure disorders

Editor,—The use of a totally implantable venous access system (Port-A-Cath) in children has become widespread in the last 15 years. We report a series of three children for whom the Port-A-Cath improved manage- ment of their refractory seizures.

Two patients both females with a diagnosis of severe myoclonic epilepsy of infancy and recurrent status epilepticus presented in the first year of life. Both had seizures, which were intractable to multiple anticonvulsants and became refractory to benzodiazepines. Intravenous midazolam was used, and to ease management of status epilepticus a Port-A-Cath was inserted at the age of 16 months in one and 4 years 3 months after insertion in the other. The third patient presented at 4 years with Lennox-Gastaut syndrome. Hospitalisation and being alert for hypoglycaemia and acido- sis is managing acute nimesulide overdose.

Port-A-Cath use in refractory seizure disorders

Editor,—The use of a totally implantable venous access system (Port-A-Cath) in children has become widespread in the last 15 years. We report a series of three children for whom the Port-A-Cath improved manage- ment of their refractory seizures.

Two patients both females with a diagnosis of severe myoclonic epilepsy of infancy and recurrent status epilepticus presented in the first year of life. Both had seizures, which were intractable to multiple anticonvulsants and became refractory to benzodiazepines. Intravenous midazolam was used, and to ease management of status epilepticus a Port-A-Cath was inserted at the age of 16 months in one and 4 years 3 months after insertion in the other. The third patient presented at 4 years with Lennox-Gastaut syndrome. Hospitalisation and being alert for hypoglycaemia and acido- sis is managing acute nimesulide overdose.

Port-A-Cath use in refractory seizure disorders

Editor,—The use of a totally implantable venous access system (Port-A-Cath) in children has become widespread in the last 15 years. We report a series of three children for whom the Port-A-Cath improved manage- ment of their refractory seizures.

Two patients both females with a diagnosis of severe myoclonic epilepsy of infancy and recurrent status epilepticus presented in the first year of life. Both had seizures, which were intractable to multiple anticonvulsants and became refractory to benzodiazepines. Intravenous midazolam was used, and to ease management of status epilepticus a Port-A-Cath was inserted at the age of 16 months in one and 4 years 3 months after insertion in the other. The third patient presented at 4 years with Lennox-Gastaut syndrome. Hospitalisation and being alert for hypoglycaemia and acido- sis is managing acute nimesulide overdose.

Port-A-Cath use in refractory seizure disorders

Editor,—The use of a totally implantable venous access system (Port-A-Cath) in children has become widespread in the last 15 years. We report a series of three children for whom the Port-A-Cath improved manage- ment of their refractory seizures.

Two patients both females with a diagnosis of severe myoclonic epilepsy of infancy and recurrent status epilepticus presented in the first year of life. Both had seizures, which were intractable to multiple anticonvulsants and became refractory to benzodiazepines. Intravenous midazolam was used, and to ease management of status epilepticus a Port-A-Cath was inserted at the age of 16 months in one and 4 years 3 months after insertion in the other. The third patient presented at 4 years with Lennox-Gastaut syndrome. Hospitalisation and being alert for hypoglycaemia and acido- sis is managing acute nimesulide overdose.

Port-A-Cath use in refractory seizure disorders

Editor,—The use of a totally implantable venous access system (Port-A-Cath) in children has become widespread in the last 15 years. We report a series of three children for whom the Port-A-Cath improved manage- ment of their refractory seizures.

Two patients both females with a diagnosis of severe myoclonic epilepsy of infancy and recurrent status epilepticus presented in the first year of life. Both had seizures, which were intractable to multiple anticonvulsants and became refractory to benzodiazepines. Intravenous midazolam was used, and to ease management of status epilepticus a Port-A-Cath was inserted at the age of 16 months in one and 4 years 3 months after insertion in the other. The third patient presented at 4 years with Lennox-Gastaut syndrome. Hospitalisation and being alert for hypoglycaemia and acido- sis is managing acute nimesulide overdose.

Port-A-Cath use in refractory seizure disorders

Editor,—The use of a totally implantable venous access system (Port-A-Cath) in children has become widespread in the last 15 years. We report a series of three children for whom the Port-A-Cath improved manage- ment of their refractory seizures.

Two patients both females with a diagnosis of severe myoclonic epilepsy of infancy and recurrent status epilepticus presented in the first year of life. Both had seizures, which were intractable to multiple anticonvulsants and became refractory to benzodiazepines. Intravenous midazolam was used, and to ease management of status epilepticus a Port-A-Cath was inserted at the age of 16 months in one and 4 years 3 months after insertion in the other. The third patient presented at 4 years with Lennox-Gastaut syndrome. Hospitalisation and being alert for hypoglycaemia and acido- sis is managing acute nimesulide overdose.
it can be familial suggesting a learnt behaviour, or developmental and emotional issues may be involved. In America it is classified as an eating disorder, in the UK it is considered a behavioural disorder; it can also be an obsessive-compulsive disorder, or a manifestation of depression.

Our children could shed no light on their compulsion. In six cases the parents found the behaviour so unacceptable that they requested psychological intervention and in four, the behaviour has now stopped. Thus whilst we find this behaviour fascinating, we are no clearer in understanding the aetiology of pica for sponge in this small population of children with SCD.

M ROBERTS-HAREWOOD
S C DAVIES
Department of Haematology, Central Middlesex Hospital, London NW10 2NS
marilyn_rae@doctors.org.uk

Maternal nutrition and pregnancy outcome

Editor,—Symonds et al raise interesting issues about the potential use of animal models in examining the impact of nutrition during pregnancy on future risk of adult disease. However, their discussion of recent epidemiological research in humans includes several important factual inaccuracies. The authors imply that our analyses and those of Godfrey et al grouped women into categories of energy intake, and suggest that different results might have been obtained had “all the raw data points [been used] to determine potential relations between maternal nutrition and birth weight”. Yet as clearly indicated in both papers1 2 this is precisely the analysis that was conducted. For information, figure 1 shows the relationship of maternal energy intake to birth weight in our study. In each paper, the cut points used in tables to illustrate the relationships between energy intake and birth weight were neither “unclear” nor “arbitrary” but were, as stated, tertiles. Symonds et al draw attention to the “striking difference” in energy intake between our study and that of Godfrey et al whilst also suggesting that we should combine our data in a meta-analysis. We argue that the differences are not particularly striking given the different methodologies used for dietary assessment. It would not be appropriate to combine in a meta-analysis data collected in contrasting ways from women at different stages of pregnancy. In any case, our study individually has sufficient statistical power to detect clinically important effects.

In animal experiments above observational epidemiology in humans, Symonds et al confuse two separate issues. First, there is the biologically interesting question of whether maternal diet can influence the outcome of pregnancy. This has already been demonstrated in animals. Secondly, there is the question of whether maternal diet does influence the outcome of human pregnancy. This question is of clinical and public health importance. It cannot be answered by animal experiments (unless one were to make the dubious argument that the errors associated with extrapolating data from animal models to humans are less than those from using self reported data on human dietary intake). We do not argue that maternal energy intake can never be associated with birth weight. Under extreme circumstances, such as those in the animal experiments cited by Symonds, or in Third World countries, it may be. However, this is no basis for suggesting is has any importance to populations in industrialised countries.

P MATTHEWS
Department of Zoology, University of Oxford, South Parks Road, Oxford OX1 3PS, UK
fmathlete@ermine.ox.ac.uk

Nitrous oxide and vitamin B12

Editor,—The paper by Kanagasundaram et al on the use of nitrous oxide to alleviate pain and anxiety during painful procedures fails to mention the effect of this gas on cobalamin metabolism. Nitrous oxide inactivates cobalamin, the active derivative of vitamin B12, and essential cofactor for the transfer of the methyl group from methylenetetrahydrofolate to homocysteine to form methionine. For subjects with good body stores of cobalamin this effect is unimportant, but no-one using this agent should remain unaware of the potentially devastating complications in the nervous system of using nitrous oxide in subjects who are of borderline or deficient vitamin B12 status. Onset of subacute combined degeneration affecting the brain and spinal cord is a well documented event when individuals with low body stores of cobalamin are exposed to nitrous oxide.

There is a long list of situations which put children at special risk of cobalamin deficiency—for example, diets low in animal products, synthetic feeding of any description, small bowel malfunction, any prolonged illness with disturbance of feeding behaviour, especially if combined with increased metabolic demands—for example, systemic malignancy or chemotherapy. Children with chronic conditions often need painful procedures, and depleted cobalamin stores may not be apparent unless measurements of serum B12 are made routinely. What is more, repeated use of nitrous oxide depletes the body stores of cobalamin even in well people.

Given the scale of use which would result from routine use of nitrous oxide in children undergoing painful procedures, there should be real concern about the potential for an accident in a child with occult cobalamin deficiency. The message must be: never forget vitamin B12 when thinking of using nitrous oxide.

ISABEL SMITH
Clinical Audit Department, Great Ormond Street Hospital, Great Ormond Street, London WC1N 3JH
smithi@gosh.nhs.uk

The outcome of specialist registrars in the southwest region

Editor,—The UK national directive is to increase consultant paediatric numbers substantially over the next 5–10 years which requires the delivery of suitably trained doctors. Higher specialist training in paediatrics is five years and there is no current evidence that the current number of trainees will produce more consultants than there are posts, so trainee numbers will still have to be reduced. The southwest regional training committee has expressed concern that trainees are not completing training within five years for a variety of reasons. We therefore reviewed the training times and outcome of the 90 specialist registrars (SpRs) who have trained in our region since the introduction of the Calman training scheme.

The impact of the high proportion of women entering paediatrics needs to be addressed. Our review confirms that 29% of trainees are training flexibly, which will increase their training time for anything up to 10 years. All these are in the flexible training scheme that requires at least six three month sessions per week. In regions where trainees have access to the retainer scheme and train for only two sessions per week, training times will be even further extended. Also our training committee is concerned that five SpRs have resigned before completing training. Four of these are women who resigned because, despite working part time, they felt that the childcare process was incompatible with family life.

Of the trainees who trained flexibly and who have obtained consultant posts, four have chosen to work as part time consultants. The other two would have done so had the opportunity been available. Female trainees will be longer to train than their male counterparts, worsen the imbalance and also time out for maternity leave. Moreover, every trainee will not necessarily translate into one whole time equivalent consultant.

In our region 47% of trainees have their Certificate of Completion of Specialist Training (CCST) date reviewed; the average time for them to complete a five year CCST programme based on current calculations is 6.3 years. Reasons include sickness.

www.archdischild.com
EDITOR,—We read with interest the paper by Dr Unsworth and wondered whether the views expressed in the latest series of food related deaths. Many minor reactors to peanut progress to more severe reactions. We think Dr Unsworth’s views of the dangers of adrenaline kits for non-medical staff are correct. Having obtained their CCST, only half of our trainees have currently obtained consultant posts; 75% of the remainder have sought training elsewhere post-CCST PhD training, lecturer posts, fellowships abroad, or training in another specialty. Therefore the total average training time is further extended. The remaining 25% are locum consultants awaiting a suitable post becoming available. All are geographically restricted and some are also specialty restricted.

Our review would therefore suggest that there is a considerable discrepancy between the number of national training numbers issued and the numbers of doctors wishing, or eligible, to take up consultant posts five years later. These issues need to be taken into account in manpower planning and in formulating, or revising, national training numbers. The number of national training numbers consultants awaiting a suitable post becoming available. The remaining 25% are locum ant posts; 75% of the remainder have sought training elsewhere post-CCST PhD training, lecturer posts, fellowships abroad, or training in another specialty. Therefore the total average training time is further extended. The remaining 25% are locum consultants awaiting a suitable post becoming available. All are geographically restricted and some are also specialty restricted.

Our review would therefore suggest that there is a considerable discrepancy between the number of national training numbers issued and the numbers of doctors wishing, or eligible, to take up consultant posts five years later. These issues need to be taken into account in manpower planning and in formulating, or revising, national training numbers. The number of national training numbers consultants awaiting a suitable post becoming available. The remaining 25% are locum ant posts; 75% of the remainder have sought training elsewhere post-CCST PhD training, lecturer posts, fellowships abroad, or training in another specialty. Therefore the total average training time is further extended. The remaining 25% are locum consultants awaiting a suitable post becoming available. All are geographically restricted and some are also specialty restricted.

Our review would therefore suggest that there is a considerable discrepancy between the number of national training numbers issued and the numbers of doctors wishing, or eligible, to take up consultant posts five years later. These issues need to be taken into account in manpower planning and in formulating, or revising, national training numbers.

The remaining 25% are locum ant posts; 75% of the remainder have sought training elsewhere post-CCST. The number of national training numbers consultants awaiting a suitable post becoming available. As Dr Unsworth points out, the adrenaline injection does not always save the child’s life.

We would suggest that when an adrenaline injection device is prescribed it must be demonstrated on both the parent and child (if the child is old enough). A dummy pen is helpful for this. Demonstration should be repeated with each repeat prescription of the device. The child and their family should always have a written management protocol, including instructions on expected symptoms, when to give adrenaline, when to call an ambulance, and when to give adrenaline. Such a protocol can then be passed rapidly to the community paediatric team to support the prompt training of school staff.

It is worth remembering that clinical responsibility for the safe administration of a drug rests with the prescriber.

MARY MCGRAW  
Regional advisor in paediatrics and chairman of the southwest regional paediatric training committee

Letters

Controversies in paediatrics?

EDITOR,—I was very disappointed to see that the first contribution to the Controversy series was not written by a paediatrician. There are plenty of controversial topics in paediatrics, including the one cited. There are also plenty of paediatricians perfectly qualified to give advice, willing to give advice, and inclusion into the topic cited. The absence of a contrasting viewpoint in the same issue suggested to me the feature should be called “Opinion” rather than “Controversy” because the article is not a balanced review of the current state of allergy practice. The BPA and latterly RCPCH have championed for decades the holistic approach to the care of children. Paediatricians are best placed to assess the integrated needs of a child with medical problems. This principle is very relevant to developing areas of specialisation in which there is short supply of expert advice, such as in allergy. Paediatric allergists assess the impact of the diagnosis on many non-medical facets of a child’s life, including family lifestyle, integration into schools and peer groups, and the facilitation of appropriateness from parental supervision. It is tiring to have to rehearse the arguments for the adequate protection of subjects at risk of anaphylaxis. Epinephrine (as all doctors should now be calling adrenaline) is not the only help given in clinic to families with an allergic child. It is part of the integrated management plan, which appears to be effective though difficult to measure.

It is very hard to prove that epinephrine saves lives and I agree with the notion of the “number needed to treat” with epinephrine to prevent a death from anaphylaxis is very high. Unsworth’s title suggests that this “very high number” (my phrase) is too high. How has he measured that? What is too many? He quotes a prevalence of about 1% of Americans having peanut allergy. That is approximately 3 million subjects. We do not restrict insulin syringes to just a few insulin dependent diabetics because diabetes is so common that we cannot adequately care for all of them. Every allergic child has the right to best available care, which is not restricted to the first 100 through the clinic door (if they can find an allergy clinic).

Laparotomy will not save every patient with a leaking aortic aneurysm. Epinephrine will not save every person who has anaphylaxis. Anaphylaxis is a critical situation in which prompt administration of epinephrine may (but occasionally may not) save a life. I think it unarguable that it is better to self treat and probably survive than not self treat and possibly die. Unsworth quotes one early paper about anaphylaxis from the US and more recent British data. These papers all go to more than that epinephrine was used due to unavailability or inappropriate training and patient confusion, rather than that epinephrine is useless or dangerous. Most subjects did not have epinephrine available. Several of the deaths described as “anaphylaxis was not used” were due to incorrect use of available epinephrine. In addition, epinephrine appears to be more dangerous in the hands of doctors who give it IV than in the hands of allergic subjects who self treat. I urge you to advise your readers look at the report on the latest series of food related deaths.

In absence of any perfect predictive test, allergists are confined to basing risk of future severe reactions on just a few variables. The first is a history of previous severe reactions. The majority of peanut allergies have had a severe reaction in the past and more than 60% have asthma, the second known association with severe reactions.

According to current opinion, then, even after just one reaction to peanut most subjects are considered at risk of severe future reactions. Many minor reactors to peanut progress to more severe reactions and epinephrine is contraindicated for those who have reacted to peanut, a food known to be associated with a risk of a severe allergic reaction.

Doctors must remember epinephrine is prescribed to be available for response to infrequent exposure at an uncertain future date, not to be taken four times a day. I have referred to this in the past as analogous to wearing a seatbelt on every car trip, every day, even though a serious car accident is unlikely on any individual day. Unsworth is not up to date in his comments about the diagnosis of IgE mediated allergy. There are strong data from huge series of challenges, about the positive and negative predictive values of the tests used in allergy clinics. Unsworth does not even mention formal challenges, the cornerstone of modern food allergy practice. The allergist would prescribe an epinephrine kit on the basis of a positive SPT in the absence of a significant historical or formal challenge.

Children and adults at risk of food related anaphylaxis have enough of life’s pleasures denied to them. The provision of epinephrine...

Families must be taught when to use epinephrine and how to use autoinjectors. Until doctors can tell families that anaphylaxis will never happen we should continue to empower families, ensuring they are ready to respond as best they can to the disaster that allergen exposure represents. When anyone develops a real treatment for food related anaphylaxis I can stop prescribing epinephrine kits to people who currently need them.

Letters

HOURIHANE Division of Infectious Disease, Inflammation and Repair, University of Southampton, Maplin Court, Tremona Road, Southampton S016 6YD, UK


Appropriate prescription of epinephrine remains the best available treatment

EDITOR,—Epinephrine kits enable a food allergic child at risk of anaphylaxis to lead a normal life and participate in childhood activities that could easily be denied by a parent terrified of another allergen exposure. Avoidance of allergens rather than rescue epinephrine therapy is the basis of current management of food allergy. However, unexpected exposures are inevitable. Fifty eight per cent of children followed for five years experienced adverse reactions from accidental peanut exposure.1 Peanut is the most common food allergen causing anaphylaxis and pervades the food processing industry. Anaphylaxis related to foods most commonly occurs in patients who have had previous severe reactions. However, minor initial reaction does not exclude a subsequent severe reaction to peanut. Any person with a history of anaphylaxis deserves the best available protection. It is reasonable to always have two Epipens available both at home and at school. A second Epipen provides back up if a faulty technique is used or one syringe is damaged. Anaphylaxis may be biphasic, recurring in 3% of children admitted with anaphylaxis.1

As advocates of children, paediatricians are unlikely to hand out epinephrine syringes without due consideration of the impact on the child and his or her family. A comprehensive plan with written information is essential for any child seen with a food allergy whether or not epinephrine is prescribed. Sicheter et al showed 20% of children did not carry epinephrine outside the home and only 55% had unexpired epinephrine on them. However, successful demonstration was associated with repeat prescriptions, membership of a lay organisation for food allergy, and being reviewed by a specialist. Training packages for schools such as that devised by Vickers in Cambridge1 are valuable.

Unsworth states that “Community use should be much more restricted with increased involvement and reliance on trained medical staff”. Food allergy is the most common cause of anaphylaxis in children outside hospital. Early recognition and use of epinephrine is vital for successful outcome. The median time to respiratory or cardiac arrest was thirty minutes following anaphylaxis in one series.4 Surely this implies that the community is the setting where epinephrine should be given by appropriately trained parents and carers to a food allergic child with signs of anaphylaxis. Parents should be empowered as limited resources prevent medical staff being present immediately. Indeed, epinephrine IV by trained medical staff also appears to be more hazardous than epinephrine IM by allergic patients.1

In the absence of any other treatments for food related anaphylaxis, the considered use of epinephrine kits as part of an integrated management plan is the best choice.

JABAY Southampton General Hospital, Tremona Road, Southampton S016 6YD, UK


Reply

EDITOR,—I was pleased to see that my article provoked lively discussion of this important issue. I am not surprised that there are many doctors concerned about poor compliance. I agree with Wolff and Rumney that adrenaline should never be the sole prescription. In addition to antihistamines, prednisolone has a place. The idea of a written management plan also appears sensible.

Hourihane contrasted prescription of adrenaline with provision of insulin syringes in diabetes mellitus. We do not restrict provision of insulin syringes in that context because to do so would inevitably deprive people of the insulin and ill health in all cases, ranging from coma to retinopathy. The risk benefit ratio is clearly in favour of daily insulin use. By contrast, the “very high” number of adrenaline prescriptions required to (perhaps) prevent death in food allergic individuals, does by contrast raise concerns about the risk benefit ratio. In our clinics, where we see large numbers of both adults and children, reviewing the last few years we have seen one fatal and two near fatal episodes related to adrenaline usage (submitted for publication). Admittedly, all three were in adults. Hourihane prescribes “epinephrine to “most (but not all) subjects who have reacted to peanuts”. He also suggests that some patients may not demand adrenaline. He would not prescribe adrenaline in the absence of a significant clinical history of true nut allergy, (and I applaud that) but others regrettably do, and I know from personal experience that once the mistake is made, it is hard to reverse. I like the seat belt analogy, but seat belts have few side effects. Regarding positive and negative predictive values of IgE based allergy blood tests, my point is that often these tests are misleading. Patients with eczema, (a common finding in those presenting with possible nut or food allergy) typically have high background IgE levels and false positives are common.

Dr Abay remarks that there is no role for medical staff including doctors may administer adrenaline incorrectly. That fact does not justify deligation of responsibility to the general public inste. They are surprised of the number of errors, despite training and/or management plans. Expecting the public to confidently decide whether to use the adrenaline or not, is expecting a lot. Fatal episodes do indeed tend to occur within minutes of allergen exposure and can evolve to anaphylaxis rapidly, even in cases where previous reactions have been benign. Families may well misjudge and/or err on the side of caution, giving adrenaline early for what was likely to turn out to be another benign reaction. Hence my keenness for restriction of community use and increased reliance on trained medical staff.

I have also noted that many thousands of children and adults experience unpleasant but essentially benign reactions each year, very few very prove fatal.1 In the community context, focusing on the higher risk groups including asthmatics would be my preference.

DJ UNSWORTH Southmead Hospital, Bristol, UK

1 Unsworth DJ. Adrenaline syringes are vastly over prescribed. Arch Dis Child 2001; 84: 410–11