



SORRY

It is a cardinal journalistic rule to bury apologies below the fold on page 94. We are breaking the rule to say sorry to authors and an editorialist, for whom we caused confusion and inaccuracy, when commenting on details of cardiac surgery at the hospital of the former.^{1,2} Please see page 313 for the correction.

FATAL FOOD ALLERGY IS A RARE EVENT . . .

Newspapers, at least in the UK, love a good scare story. For the last few months they have done their best to demonise MMR vaccine—but once the fuss dies down it may be back to normal with food allergy. If you ask the average reader (or supermarket shopper) if severe food allergy is common, the answer is likely to be “Yes”. So, as an average reader of *ADC* how many children do you think die in the UK each year from food allergy: 1000? 10? 100? To find out if you are right take a look at Macdougall and colleagues’ paper which has attempted to collate all such deaths since 1990.

So far as severe, but not fatal, reactions are concerned, the authors obtained prospective data for 1998–2000 through the British Paediatric Surveillance Unit. The incidence turned out to be less than 2 events per million children per year—reassuring, although less reassuring was the finding that a previous mild reaction does not make a future severe reaction less likely. In the prospective study, all 3 fatal cases, and all but one of those near-fatal, were in children with a history of asthma. Pre-hospital epinephrine failed to save two of the three children and the authors refer to another fatality ascribed by the Coroner to an overdose of this drug given intravenously. One message is to treat asthmatics optimally—which we don’t yet do.³

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. . . BUT COUGHING BEFORE ASTHMA ISN’T

If we are to treat asthmatics optimally then we need to control exacerbations, and hopefully prevention might be better than cure. Chang and colleagues, from Alice Springs, Australia, comment on the lack of prospective data on markers of airway inflammation, which surely makes prevention strategies precarious. They studied associations between conventional clinical variables in asthma, cough indices and inflammatory markers in blood and sputum, from baseline, through acute mild exacerbation to resolution. Clinical markers of the sort detailed in asthma diaries proved insensitive as predictors of deterioration. Sputum eosinophilic cationic protein (ECP) went up, reaching a peak as asthma subsided. Previously identified coughers coughed more before their asthma became worse; but cough scores and cough receptor sensitivity were poorly associated with ECP during acute episodes. The authors speculate that the former might be mediated through neutrophil inflammation.

Future studies will be welcome if they help decide what to do with little coughers, now that we read (as opposed to knowing in the depths of our souls) that cough suppressants don’t help.^{4,5}

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AIR GUNS, GOOD AND BAD

We all have long held shameful secrets: mine was of shooting a cat with my brother’s air gun when I was about 9 years old. This confession may seem unimportant to readers outside the UK but the last time an author admitted to deliberate cat abuse in the *BMJ*, there were 40 letters of complaint, several readers cancelled their subscription and two resigned from the British Medical Association in protest.⁶ This month we look at air weapons from two distinct viewpoints. Ceylan and co-authors from Leeds, UK, discovered 36 child attenders at their accident and emergency department who had suffered injuries from air weapons (out of 73 total injuries). Four children had intra-abdominal or deep cervical trauma. They place their survey in context by noting that UK crime statistics show a steady increase in offences using air weapons, doubling in the last 10 years to over 10 000 recorded crimes. Although no children in the UK have been deliberately killed in this way in recent years, accidental deaths have been reported.

Most conventional air weapons do not require a licence and children under 14 are allowed to use them under adult supervision. In view of the increasing power of modern air guns, the authors call for co-ordinated action by the police, sporting associations, manufacturers, retailers, politicians and the public.

Our other air (or more precisely, helium) weapon story is a happier one: A group from the paediatric intensive care unit in Bristol, UK report on their experience injecting local anaesthetic into the skin at high velocity using the Powderject device.

Nine out of ten children reported satisfactory analgesia on venepuncture in the antecubital fossa. Intriguingly, over 50% of controls (sham injection) reported painless venepuncture, perhaps a tribute to the skill of the investigators, and there was no difference between the groups when injected at the back of the hand. The authors hope that further refinement of the device will bring it into clinical practice; it provides analgesia within about 3 minutes—a considerable time-saving when compared with topical anaesthesia.

See pages 234 and 309

- 1 Salmon AP. Hypoplastic left heart syndrome—outcome and management. *Arch Dis Child* 2001;**85**:450–1.
- 2 Andrews R, Tulloh R, Sharland G, et al. Outcome of staged reconstructive surgery for hypoplastic left heart syndrome following antenatal diagnosis. *Arch Dis Child* 2001;**85**:474–7.
- 3 Child F, Davies S, Clayton S, et al. Inhaler devices for asthma: do we follow guidelines? *Arch Dis Child* 2002;**86**:176–9.
- 4 Schroeder K, Fahey T. Systematic review of randomised controlled trials of over the counter cough medicines for acute cough in adults. *BMJ* 2002;**324**:329.
- 5 Schroeder K, Fahey T. Should we advise parents to administer over the counter cough medicines for acute cough? Systematic review of randomised controlled trials. *Arch Dis Child* 2002;**86**:170–5.
- 6 Farrell L. An encounter with Reynard. *BMJ* 1997;**315**:686.