If you have a burning desire to respond to a paper published in *Arch Dis Child* or *F&N*, 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 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.

### C difficile induced pneumatosis intestinalis in a neutropenic child

A 4 year old boy presented with a 24 hour history of fever, cramping central abdominal pain with distension, and bloody diarrheal stools. He had developed acute myeloblastic leukaemia at the age of 1. He eventually required a matched unrelated graft which engrafted successfully but acidosis and portal gas are associated with a poor outcome.

Temperature was 38.5°C, pulse 150/min; he had abdominal distension and tenderness but no ascites.

An abdominal film (fig 1) revealed dilatation of the colon with gaseous linear tramlining of the bowel wall consistent with pneumatosis intestinalis (PI). Stools were positive for *Clostridium difficile* toxin A. PI resolved with bowel rest, intravenous fluids, meropenem, and metronidazole but he later died of relapsed leukaemia.

PI is described in children in Crohn’s disease, ulcerative colitis, leukaemia, trauma, HIV, and GVHD after BMT. *C difficile*, pseudomembranous colitis, and PI are reported in an immunocompetent adult patient. Conservative management is usually successful but acidosis and portal gas are associated with a poor outcome.

**Figure 1** Abdominal film showing dilatation of the colon and PI.

**References**


**CORRECTION**

We would like to acknowledge an error that was made in our article previously published in the journal (Arch Dis Child 2000;83:18–24). The absolute amount of grams consumed per day for the figures presented in the article were incorrect. An error was made in calculating the mean intake when the age groups (11–14 and 15–18) were combined. The corrected amounts are listed in the following table. This error does not change the trends or interpretation of results previously reported. A Maria Siega-Riz and B Popkin apologise for this unfortunate circumstance.

Please see the Archives website (www.archdischild.com) to view the corrected figures.
PKS who attend this hospital, an 8 year old girl and a 10 year old boy. Only one of the three patients possesses the HLA DR15 (DR2) DQB1*0602 haplotype that is strongly associated with the narcolepsy-cataplexy syndrome.

Cataplexy is usually precipitated by emotion provoking laughter, anger, or joy. The affected individual often falls to the ground without losing consciousness and the phenomenon is often mistaken for an epileptic or cardiac event. It can occur in isolation as a dominantly inherited trait or in association with a number of other conditions (table 1). The association between PWS and cataplexy, though described previously, is not widely recognised. Suspected episodes of cataplexy have been reported in eight of 35; four of 25; and three of 17 patients with PWS. However, cataplectic manifestations are often “difficult to prove”, requiring a detailed history that is perhaps seldom available or elicited. We suggest that cataplexy may be relatively common in PWS and enquires regarding its signs and symptoms should be included in any patient with a past diagnosis of paroxysmal events.

E S Tobias, J L Tolmie
Duncan Guthrie Institute of Medical Genetics, Yorkhill Hospitals, Glasgow G3 8SJ, UK; gbev55@ucl.ac.uk

J B P Stephenson
Fraser of Allander Neurosciences Centre, Royal Hospital for Sick Children, Yorkhill, Glasgow G3 8SJ, UK

References

Kawasaki disease following meningooccal septicaemia

We report a case of Kawasaki disease (KD) following meningooccal septicaemia which we believe has not been described before. A 14 month old boy presented to his local hospital with a four day history of being unwell, fever, and blanching maculopapular rash. Meningooccal septicaemia was diagnosed clinically and the boy was managed with fluid support and intravenous antibiotics. His recovery was complicated by developing respiratory syncytiotial virus positive bronchiolitis and secondary surgical emphysema. Polymerase chain reaction was positive for group B meningococcus on day 3. Blood and urine cultures were negative. He continued to spike high temperatures in the ward, a lumbar puncture performed on day 13 showed normal cerebrospinal fluid microscopy and biochemistry. Other investigations, including cranial computed tomography scan of his head and abdominal ultrasound (including renal vessel Doppler studies) were all normal. He continued to spike high temperatures with pleomorphic crytomatous rash, non-purulent conjunctivitis, red enlarged lips, red gums, red inflamed tongue, and axillary lymphadenopathy of >1.5 cm. A clinical diagnosis of KD was made; he was treated with intravenous immunoglobulin and aspirin with good effect. Platelet count on day 14 was 933 (admission platelet count was 187). On day 18 he was noted to have mild peeling of his scrotum, hands, and feet. An echo cardiogram showed left coronary artery ectasia. He was discharged on day 22 with follow up arrangements including repeat echocardiogram. He was, however, lost to follow up and no further data are available.

Discussion

A number of epidemiological and clinical observations suggest that KD may be caused by an infectious agent. These include geographic clustering of outbreaks, often with a seasonal predominance and the acute self limited nature of the illness. Many of the clinical features of KD are shared by those of other infectious diseases, for example, adenoviral infection and scarlet fever. Streptococci, streptococci, and Epstein–Barr virus are some of the infectious agents implicated in KD.

An unusual degree of immune activation caused by bacterial and viral protein toxins acting as superantigens is currently considered to be the basis of pathology in KD. We believe that our case shows the possibility that a meningococcal toxin could act as a superantigen to cause KD. We were unable to find any published record of such an association in the literature. The currently proposed hypothesis to explain the pathogenesis is that a genetically susceptible host becomes colonised on the mucous membranes of the gastrointestinal tract by an organism that produces a toxin which behaves as a superantigen. We propose that a toxin producing meningococcus could cause KD in the same fashion as toxic shock syndrome toxin producing Staphylococcus aureus. It is possible that our patient coincidentally had both illnesses at around the same time. Understanding the aetiology of KD remains a major unresolved issue in paediatrics. Although there is no conclusive data to support the superantigen induced disease theory for KD, evidence suggesting that superantigens may mediate KD is growing.

A V Ramanan, E M Baildam
Department of Paediatric Rheumatology, Royal Manchester Children’s Hospital, Manchester, UK. Correspondence to: Dr A V Ramanan, 508, 77 Elm Street, Toronto, Ontario M5G 1H4, Canada; avramanan@hotmail.com

References

Problems involved with the use of comforters

While I share many of the concerns expressed by Gill1 in his diatribe on dummies there are a number of issues which warrant further amplification or correction. The first patent on the India rubber nipple resembling the present day dummy was recorded in 1845 and was described in use in its present form in London by 1927. Unfortunately by this time the practice of dipping the dummy in a variety of sweetening agents to make it a more effective pacifier had become established and this habit was noted to be associated with the early onset of dental caries. No doubt the loss of primary incisors mentioned by Gill is due to their destruction by rampant dental caries associated with the persistent use of sweetened pacifiers and their subsequent extraction due to spreading infection, pain, and loss of sleep. The association of dummy sucking with malocclusion is more complex than stated. While there is a general agreement on the effect of prolonged dummy sucking producing malocclusions in the primary dentition, these abnormalities are mainly self corrective on cessation of the habit which is usually before 5 years of age.

G B Winter
Emeritus Professor of Children’s Dentistry, 1 Hanfield Close, Elstree, Herts WD6 3JD, UK

References

Cataplexy in the Prader–Willi syndrome

We report cataplexy, sudden atonic episodes provoked by emotion, in three patients with Prader–Willi syndrome (PWS) and suggest that cataplexy may be relatively common in this condition.

Detailed questioning of the mother of an 18 year old woman who had PWS elicited a history of recurrent attacks, apparently induced by laughter, with sudden loss of power in all the patient’s limbs. If standing, she would slump to the floor but recover completely after a few seconds. She had no history of the sleep paralysis or hypnagogic hallucinations and there was no family history of cataplexy, narcolepsy, or epilepsy. Her EEG was unremarkable. Episodes of cataplexy and of narcolepsy, despite excellent weight control, have been reported by two other patients with

Table 1 Conditions in which cataplexy is a recognised feature

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familial isolated cataplexy</td>
</tr>
<tr>
<td>Norrie’s disease</td>
</tr>
<tr>
<td>Niemann–Pick disease type C</td>
</tr>
<tr>
<td>Coffin–Lowry syndrome</td>
</tr>
<tr>
<td>Narcolepsy–cataplexy syndrome</td>
</tr>
<tr>
<td>Fontanomediastaly/hypothalamic structural lesions</td>
</tr>
</tbody>
</table>

LETTERS
creased alkaline phosphatase, but normal an N-acetylglucosamine:creatinine ratio of generalised aminoaciduria, phosphaturia, and gated hyperbilirubinaemia within two days. Metabolic acidosis developed also present. Icthyosis was present.

A female infant, born to consanguineous range of phenotypes ARC syndrome: an expanding glutamyltransferase.

specimens all showed giant cell trans-colleagues, in whose patients the liver biopsy varies from that reported by Eastham and died at the age of 10 months. Repeated episodes of the blood or faeces at the time of the original life (no organisms were identified in either specimens).

Renal tubular acidosis was manifest by inflammatory changes. No giant cells were present.

Recurrent episodes of necrotising enterocolitis occurred during the first two months of life (no organisms were identified in either the blood or faeces at the time of the original or recurrent episodes). Repeated episodes of septicaemia occurred later. Marked failure to thrive persisted despite high calorie enteral feeds and correction of acidosis. The patient died at the age of 10 months. This patient differs in two ways from previous reported cases. Firstly, liver histology varies from that reported by Eastham and colleagues, in whose patients the liver biopsy specimens all showed giant cell transformation. It may be possible that the histology did not show typical features due to early timing of the biopsy. It is however possible that our case represents a phenotypic variant of the same disorder.

Secondly, we believe our case to be the first reported to have necrotising enterocolitis. No immunodeficiency has been identified in our patient, unlike others in the literature. It was noteworthy that the patient was receiving hyperosmolar formula feeds at the time of the first episode. The occurrence of necrotising enterocolitis should warn clinicians of the potential risk of hyperosmolar feeds in severely growth retarded infants with acidosis, even when born at or after term.

References

Echocardiography on the neonatal unit
Two dimensional, M mode and Doppler echocardiography is widely used by paediatric cardiologists to evaluate cardiac structure and function in neonates, infants, and older children. Anecdotally, it is also being used increasingly by neonatologists in the early newborn period. We have recently undertaken a postal questionnaire survey of 38 neonatologists working in referral centres to review current UK practice. Thirty seven neonatologists responded to the questionnaire. Nineteen units performed more than 15 echocardiograms per month, six performed 10–15/month, and 12 performed less than 10/month. Echocardiograms were usually performed by paediatric cardiologists and/or neonatologists, but also occasionally by echocardiographic technicians. Neonatologists performed echocardiograms in two thirds of responding units. The commonest indications for echocardiography were: diagnosis/exclusion of congenital heart disease, assessment of ductal patency and haemodynamics, assessment of myocardial function, and assessment of pulmonary hypertension.

Only 12 (32%) units had 24 hour access to paediatric cardiology service on site; of those who did not, 18 units usually had access to these services on an on-call basis. Babies were transferred out of the neonatal unit for echocardiography in 13 (35%) responding units. Indomethacin was used to treat a symptomatic persistent ductus arteriosus (PDA) following a purely clinical diagnosis in 15 (41%) units.

This survey shows that echocardiography on the neonatal unit is often performed by a neonatologist rather than a cardiologist, presumably reflecting the (lack of) availability of 24 hour on-site paediatric cardiology services, even in neonatal referral centres. In a considerable number of units babies are either transferred out of the neonatal unit for echocardiographic assessment or receive treatment for PDA without prior echocardiographic confirmation. Such situations are undesirable and reflect the need for greater access to echocardiography on the neonatal unit, a service that is likely to be provided increasingly by neonatologists themselves in the future.

Although several paediatric echocardiography courses are available, currently there is no formal accreditation process for neonatologists. We believe there is a need to evaluate the reliability of echocardiography in the hands of neonatologists in a systematic way and are currently conducting such a study.

S Moss, N V Subhedar
Liverpool Women’s Hospital, Crown Street, Liverpool L8 7SS, UK; nvsubahdedar_lwh@yahoo.com

References

In July's Archives (Arch Dis Child 2002;87:85), the correction mentioned “the following table”: this was incorrect. The sentence should have read “The corrected amounts are listed in the revised figures”. No table was missing, and readers can view the revised figures at www.archdischild.com, as mentioned in the original correction. We apologise for the error.

Please see the Archives website (www.archdischild.com) to view the corrected figures.