Problems involved with the use of comforters

While I share many of the concerns expressed by Gill in his diatribe on dummies there are a number of other factors which suggest 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 in 1887. Unfortunately at 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.

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References

Cataplexy in the Prader–Willi syndrome

We report cataplexy, sudden atomic 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 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 always be made, especially in any patient with a past diagnosis of paroxysmal events.

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References

Kawasaki disease following meningoencephalitis

We report a case of Kawasaki disease (KD) following meningoencephalitis 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. Meningococcal sepsicaemia was diagnosed clinically and the boy was managed with fluid support and intravenous antibiotics. His recovery was complicated by developing respiratory syncytial 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 brain and abdominal ultrasound (including renal vessel Doppler studies) were all normal. He continued to spike high temperatures with pleomorphic erythematous rash, non-purulent conjunctivitis, red enlarged lips, red gums, red inflamed tongue, and axillary lymphadenopathy > 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 echocardiogram showed left coronary artery ectasia. He was discharged on day 25 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 could always be made, especially in any patient with a past diagnosis of paroxysmal events.

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References
conjugated hyperbilirubinaemia, greatly in- findings to those previously reported, with >1000. Liver investigations revealed similar generalised aminoaciduria, phosphaturia, and gated hyperbilirubinaemia within two days. within a few hours of birth and severe conjugated hyperbilirubinaemia within two days. Renal tubular acidosis was manifest by generalised aminoaciduria, phosphaturia, and an N-acetylglucosamine:creatinine ratio of >1000. Liver investigations revealed similar findings to those previously reported, with conjugated hyperbilirubinaemia, greatly increased alkaline phosphatase, but normal γ glutamyltransferase. Plasma and urinary bile acids were normal. Histology of the patient’s liver revealed the presence of normal numbers of bile duct and no lipofuscin deposition or 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 sepsis 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. Seco-ondly, 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 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 most common 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 35% (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.

References

CORRECTION

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.