We report cataplexy, sudden atonic episodes provoked by emotion, in three patients with PWS and cataplexy syndrome. 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 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 girl who had 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 PWS 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,7 is not widely recognised. Suspected episodes of cataplexy have been reported in eight of 35,4 four of 25,1 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 enquiries regarding its signs and symptoms should always be made, especially in any patient with a past diagnosis of paroxysmal events.

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Table 1: Conditions in which cataplexy is a recognised feature

| Condition/Genetic Abnormality | Cataplexy
|-------------------------------|--------------------
| Familial isolated cataplexy    | Varies
| Norrie’s disease               | Varies
| Niemann–Pick disease type C    | Varies
| Coffin–Lowry syndrome          | Varies
| Narcolepsy–cataplexy syndrome  | Varies
| Pantomimedullary/hypothalamic structural lesions | Varies

Kawasaki disease following meningoococal septicaemia

We report a case of Kawasaki disease (KD) following meningoococal 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. Meningococcal septicaemia 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 inflamed tongue, and auxillary 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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findings to those previously reported, with an N-acetylglucosamine:creatinine ratio of also present. Metabolic acidosis developed hips and rocker bottom feet. Icthyosis was palate, and arthrogryposis with dislocated prominent occiput, beaked nose, high arched ARC syndrome: an expanding glutamyltransferase.

varies from that reported by Eastham and ose reported cases. Firstly, liver histology died at the age of 10 months. Marked failure to thrive persisted despite high calorie enteral septicaemia occurred later. Marked failure to survive persisted even when born at or after term. Recurrent episodes of necrotising entero-colitis 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 previously 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.

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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 10 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.

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.