Wheeze in early childhood is common, occurring in approximately 50% of children before the age of 6 years. Understanding the role of respiratory viruses in triggering acute wheezing in children has been compromised by the lack of comparison groups in previous studies.

The objective of this study was to investigate the association (using a control group) of two common viruses—influenza virus and respiratory syncytial virus (RSV)—with acute wheezing among children, aged 1–7 years, with a past history of wheezing.

METHODS
Children, aged 1–7 years, with two or more previous wheezing episodes, were enrolled from a paediatric community practice and an emergency department during two consecutive winters (1997/1998, 1998/1999) into this concurrent case–control study.

Cases had previous wheezing and current symptoms of an upper respiratory infection and acute wheezing (clinical score of at least 1). Controls had previous wheezing and current symptoms of an upper respiratory tract infection, without acute wheezing (clinical score of 0) at the time of enrolment or within the week following enrolment. Children were excluded if they had received immunisation for influenza in the year of enrolment. Consent was obtained.

RESULTS
Baseline characteristics were collected and wheezing severity was graded using a clinical score (minimum to maximum range: 0–10). Nasopharyngeal swab specimens were collected and examined for influenza viruses A and B and RSV by immunofluorescence microscopy (antibodies from Light Diagnostics, Temecula, CA) and cell culture (RMK cells: Viromed Diagnostics, Minneapolis, MN; and MDCK cells: American Type Culture Collection, Rockwood, MD).

The odds ratio and 95% confidence interval were determined for influenza virus and RSV in children with acute wheezing (cases) relative to children with upper respiratory symptoms alone (controls). Separate analyses were undertaken for community cases versus controls, and all cases (community and emergency cases) versus controls.

Table 1 shows baseline characteristics. Table 2 shows the association between acute wheezing and virus infection. For influenza virus, the odds ratio indicates that infection is not associated with acute wheezing. The adjusted odds ratio (all cases versus controls) for the risk of acute wheezing in those with influenza was 0.52 (95% confidence interval, 0.27 to 1.03). For RSV, the odds ratio indicates that infection is associated with a threefold increase in the risk of acute wheezing.

Children with influenza virus (n = 43) and RSV (n = 58) were compared. Children with influenza virus were older (median age 3.6 years v 2.4 years, p = 0.002), had a lower

Table 1 | Baseline characteristics—community cases, emergency department cases, controls

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Community cases (n=89)</th>
<th>Emergency cases (n=84)</th>
<th>All cases (n=173)</th>
<th>Controls (n=106)</th>
<th>p value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y), median (range)</td>
<td>3.1 (1.1–7.0)</td>
<td>3.1 (1.0–6.7)</td>
<td>3.1 (1.0–7.0)</td>
<td>3.2 (1.0–7.0)</td>
<td>0.11</td>
</tr>
<tr>
<td>Clinical score, median (range)</td>
<td>1 (1–9)</td>
<td>5 (1–9)</td>
<td>3 (1–9)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Sex (% male)</td>
<td>61 (69)</td>
<td>48 (57)</td>
<td>109 (63)</td>
<td>66 (62)</td>
<td>0.90</td>
</tr>
<tr>
<td>Smoke exposure (% exposed)</td>
<td>22 (25)</td>
<td>20 (24)</td>
<td>42 (24)</td>
<td>18 (17)</td>
<td>0.15</td>
</tr>
<tr>
<td>Family history of asthma (%)</td>
<td>49 (55)</td>
<td>46 (54)</td>
<td>95 (55)</td>
<td>64 (60)</td>
<td>0.37</td>
</tr>
<tr>
<td>Atopy (%)</td>
<td>11 (12)</td>
<td>45 (54)</td>
<td>56 (32)</td>
<td>13 (12)</td>
<td>0.0002</td>
</tr>
<tr>
<td>Daycare (%)†</td>
<td>25 (35)</td>
<td>30 (43)</td>
<td>55 (39)</td>
<td>36 (44)</td>
<td>0.45</td>
</tr>
</tbody>
</table>

Values are medians or numbers (range or percentages).
*All cases v controls.
†Of preschool aged children.

Table 2 | Association between acute episodes of wheezing and influenza virus and RSV infections

<table>
<thead>
<tr>
<th>Variable</th>
<th>Community cases (n=89)</th>
<th>All cases (n=173)</th>
<th>Controls (n=106)</th>
<th>p value</th>
<th>Odds ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza (% positive)</td>
<td>14 (16)</td>
<td>20 (12)</td>
<td>23 (22)</td>
<td>0.30*</td>
<td>0.67*</td>
<td>0.30 to 1.49*</td>
</tr>
<tr>
<td>RSV (% positive)</td>
<td>23 (26)</td>
<td>47 (27)</td>
<td>11 (10)</td>
<td>0.005*</td>
<td>3.01*</td>
<td>1.29 to 7.11*</td>
</tr>
</tbody>
</table>

Values are numbers (percentages).
*Community cases v controls.
†All cases v controls.
median clinical score (0 v 2, p < 0.001), were more likely to be recruited from the community practice (87% v 59%, p = 0.003), and were less likely to be wheezy acutely (47% v 81%, p = 0.0003), compared to children with RSV. There were no differences in sex, history of smoke exposure, family history of asthma, and history of atopy.

DISCUSSION
When cases and controls were analysed for the viral aetiology of their respiratory illness, cases were three times as likely to be infected with RSV, but almost half as likely to be infected with influenza virus compared with controls. This finding existed in both the community and emergency department setting. An extensive body of literature, summarised by Pattemore and colleagues,\(^7\) has found that influenza virus and RSV are commonly identified in wheezing illnesses and asthma exacerbations occurring in childhood. The interpretation of these studies is compromised in that control groups were not included for comparison. The unique contribution of our study was the inclusion of a control group, to allow for an estimate of the strength of the association.

Our study may be limited by the case–control study design. Although a prospective cohort study would be appropriate, this would be an intensive and invasive process, requiring participants to undergo repeated nasopharyngeal swabs, both when symptomatic (wheezing) and asymptomatic (not wheezing). Therefore, we designed a case–control study, in which controls were chosen to be free of wheezing (outcome) but comparable to cases with respect to risk of exposure. Thus, controls were selected from those individuals seeking care for broadly defined symptoms of an upper respiratory infection. A strength of the design was the inclusion of both community and emergency department controls. Furthermore, determination of outcome (wheezing) and exposure (virus infection) was conducted concurrently.

An unexpected finding was the trend of the association between influenza virus and wheezing, suggesting that infection might actually be associated with a reduced risk of wheezing (adjusted odds ratio 0.52, 95% confidence interval, 0.27 to 1.03). While this may have been a chance finding, it contrasts with previous studies, which have found a high influenza virus related morbidity in children with recurrent wheezing and asthma.\(^4\)

New hypotheses have emerged regarding the role of viruses in promoting or preventing the development of persistent wheezing and asthma.\(^1\) Exposure to older children at home, children at day care, and repeated viral infections (other than lower respiratory tract infections) are thought to be protective.\(^5,6\)

Understanding the role of respiratory viruses in triggering acute wheezing, and in the long term development or prevention of recurrent wheezing, will be important when considering strategies such as immunisation and antiviral therapy. In this context, we conclude that in our study the role of influenza virus in triggering acute wheezing in young susceptible children less than 7 years of age was weak, while the role of RSV in these children was strong.

References
If you have a burning desire to respond to a paper published in ADC or FE\textsubscript{M}, 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.

**Problems with scoring bruises**

We write to draw attention to two problems with the recent study on a scoring system for bruising by Dunstan et al.\textsuperscript{1}

Firstly, the authors did not publish confidence intervals for the likelihood ratios (LRs) derived from different score threshold values (table 3), thereby not allowing readers to judge whether the LRs are statistically—let alone clinically—significant.\textsuperscript{2} Secondly, the authors neglect the phenomenon of spectrum bias. This is a well described feature of many tests, whereby sensitivity and specificity (and hence derived LRs) of a test vary with disease severity or prevalence. Examples of spectrum bias have been described with several tests including exercise stress testing\textsuperscript{3} and UTI diagnosis.\textsuperscript{4}

The study population had a prevalence of physical abuse of 40%, much higher than the lower prevalence of physical abuse than the study this reduces the value of the proposed scoring system as a clinical tool.

M Williams
Intensive Care Unit, Charing Cross Hospital, London, W6 8RF, UK

B Krishnan
Department of Paediatrics, Guy’s Hospital, London SE1 9RT, UK

Correspondence to Dr Williams; matthew.williams@uccx.com

**References**


**Does cefotaxime eradicate nasopharyngeal carriage of N meningitidis?**

We enrolled 43 children admitted with an unequivocal clinical diagnosis of meningococcal sepsis into a study to determine whether cefotaxime eradicated nasopharyngeal carriage of N meningitidis. In 28 cases (70%) the diagnosis was confirmed by positive culture from blood, nose, throat, or skin scraping, detection of meningococcal DNA in blood by polymerase chain reaction, or convalescent meningococcal serology. All children were treated with intravenous cefotaxime for seven days. Nasopharyngeal and throat swabs were obtained on the day of admission in 42 of these children, and all children had swabs repeated every day until there were at least two negative swabs.

On admission, the throat and nasopharyngeal swabs were both positive for meningococcus in two patients; in another two patients, the nasopharyngeal swab was positive while the throat swab was negative. In three patients the swabs became negative after 24 hours of treatment, and in one child it became negative after 48 hours. In these children and others in whom the swabs were negative from the day of admission, subsequent swabs remained negative.

Compared to a previous study\textsuperscript{1} that reported a nasopharyngeal carriage rate of 50% on admission and showed that the yield of meningococcus in throat swabs was unaffected by prior administration of penicillin, the yield from throat and nose swabs in this study (9.5%) was poor. This may reflect the fact that in practice many of these swabs were taken after the child had been given the first dose of cefotaxime. The study findings suggest that cefotaxime, like ceftriaxone,\textsuperscript{2} is effective in eradicating nasopharyngeal carriage, and in children treated with cefotaxime, additional prophylaxis with rifampicin is not necessary. However, no recommendations for the use of cefotaxime alone can emanate from these findings as the sample size was small and study design did not compare cefotaxime with gold standard treatment (either rifampicin or ceftriaxone). We are keen to coordinate a follow up multicentre study this winter involving paediatric intensive care units across the country to compare the efficacy of ceftriaxone with cefotaxime on eradication of meningococcal carriage. Interested units are kindly requested to contact us.

J Clark, R Lakshman, A Galloway, A Cant
Newcastle General Hospital, Newcastle
Correspondence to: J Clark, Department of Child Health, Newcastle General Hospital, Newcastle upon Tyne NE4 6EE, UK; julia.clark@nuth.northy.nhs.uk

**References**


**Pneumocystis carinii pneumonia in an infant with transient hypogammaglobulinaemia of infancy**

Transient hypogammaglobulinaemia of infancy (THI) is characterised by prolongation of the physiological decline in serum immunoglobulin concentrations seen in the first six months of life.\textsuperscript{1} The incidence reported from an Australian paediatric centre was estimated as 23 per 10\textsuperscript{5} live births.\textsuperscript{2} It has been reported that THI does not usually predispose to significant infection.\textsuperscript{3}

A male infant born at term to non-consanguineous parents presented at 3.5 months with cough, tachypnoea (70 breaths/minute), wheeze, crepitations, and hypoxia. A chest radiograph showed bilateral patchy infiltration and patchy opacification in the hilar regions and upper lobes. *Pneumocystis carinii* was identified in brochoalveolar lavage by toluidine blue staining. The immunological findings of this child were consistent with those of THI with an IgG level less than the fifth centile\textsuperscript{4} and absent serum IgA\textsuperscript{5} which resolved with age (IgG at presentation 3.9 g/l (normal: 1.39–8.04); at 5 months 2.23 (1.39–8.04); at 10 months 1.77 (2.02–11.76); at 17 months 7.51 (2.71–13.78); IgA at 5 months <0.07 g/l (normal: 0.14–0.69); at 13 months 0.14 (0.17–1.34)) and evidence of specific antibody production to tetanus, diphtheria, and *Haemophilus influenzae* type b following immunisation.\textsuperscript{6} T cell numbers (total lymphocytes 6.2 x 10\textsuperscript{9}, CD3 68%, CD4 56%, CD8 15%) and phytohaemagglutinin induced proliferation were normal. At 3 years the child was well with normal IgG, IgA, and IgM levels.

*Pneumocystis carinii* pneumonia presenting in the first three months of life is an infection typically seen in patients with significant T cell immunodeficiencies and X linked hyper IgM. These were excluded by normal T cell numbers and function and by normal CD40 ligand expression and mutation analysis. There are reports of *Pneumocystis carinii* pneumonia in immunocompetent infants\textsuperscript{7} and agammaglobulinaemia.\textsuperscript{8} This is the first description of *Pneumocystis carinii* pneumonia in a patient with THI.

J M Smart, A S Kemp
Department of Immunology, Royal Children’s Hospital, Flemington Road, Parkville 3052, Australia; kemp@cryptic.rch.unimelb.edu.au

D S Armstrong
Department of Respiratory Medicine, Royal Children’s Hospital

**References**


Procalcitonin as a prognostic marker in children with meningococcal septic shock

Carrol and coworkers\(^1\) confirm the findings from Karabocuglu et al who reported that procalcitonin (PCT) was higher in children with severe meningococcaemia (fever, petechiae or purpura, and hemodynamic instability) than in children with systemic meningococcal infection without shock (291.29 ± 167 vs. 19.7 ± 23 ng/ml; p < 0.001).\(^2\)

Unfortunately, information is lacking in the report of Carrol et al,\(^1\) namely: a clear definition of severe MCD (defined in their paper as a Glasgow Meningococcal Septicaemia Prognostic Score ≥8) and median PCT values at admission or at the time of death. Sensitivity, specificity, positive and negative predictive index, we calculated the area under the ROC curve (AUC 0.73 (0.59–0.88)) for PCT, CRP, PRISM value and PRISM probability of death calculated within 24 hrs of admission or at the time of death, and more accurate than the CRP level in classifying survivors and nonsurvivors of MSS. These results accord with those of Hatherill et al who observed, in 37 children with MSS, that admission PCT levels (values not indicated) were higher in nonsurvivors (11%) than in survivors (p = 0.04) and related to the severity of organ failure (p = 0.02), however, in the whole group of children with septic shock whatever the causative organism, admission PCT functioned worse than the PRISM score whatever the causative organism, admission PCT functioned worse than the PRISM score.

In our study, PCT on admission was as accurate as the PRISM value and PRISM probability of death calculated within 24 hrs of admission or at the time of death, and more accurate than the CRP level in classifying survivors and nonsurvivors of MSS. These results accord with those of Hatherill et al who observed, in 37 children with MSS, that admission PCT levels (values not indicated) were higher in nonsurvivors (11%) than in survivors (p = 0.04) and related to the severity of organ failure (p = 0.02), however, in the whole group of children with septic shock whatever the causative organism, admission PCT functioned worse than the PRISM score. However, as it needs a 24 hour observation period, it cannot be used as an inclusion criterion for clinical trials. Admission PCT could represent a good alternative tool if further studies confirm its ability to predict mortality.

Table 1 Performance characteristics of PCT, CRP, and PRISM score in 35 children with MSS

<table>
<thead>
<tr>
<th>Severity index (%)</th>
<th>PCT</th>
<th>CRP</th>
<th>PRISM value</th>
<th>PRISM probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>100</td>
<td>64</td>
<td>100</td>
<td>91</td>
</tr>
<tr>
<td>Specificity</td>
<td>63</td>
<td>46</td>
<td>63</td>
<td>83</td>
</tr>
<tr>
<td>Positive predictive value</td>
<td>54</td>
<td>35</td>
<td>54</td>
<td>54</td>
</tr>
<tr>
<td>Negative predictive value</td>
<td>100</td>
<td>46</td>
<td>100</td>
<td>95</td>
</tr>
<tr>
<td>Well classified</td>
<td>74</td>
<td>51</td>
<td>74</td>
<td>86</td>
</tr>
</tbody>
</table>

Figure 1 ROC curves (AUC SE) for PCT, CRP, and PRISM score in 35 children with MSS. PCT v PRISM value, p = 0.045; PCT v PRISM probability, p = 0.31; PCT v CRP, p = 0.06; CRP v PRISM value, p = 0.01; CRP v PRISM probability, p = 0.10.

References


Incidence of severe and fatal reactions to foods

Although the article by MacDougall et al\(^1\) regarding the incidence of severe and fatal reactions to food would be seem to be reassuring, we would like to express some concerns and raise some questions about the data presented. The first question is whether the ascertainment of cases is really as complete as the authors suggest. We acknowledge that the UK medical system may allow better reporting and access to mortality data than that of the US. However, as a 24 hour observation period, it cannot be used as an inclusion criterion for clinical trials. Admission PCT could represent a good alternative tool if further studies confirm its ability to predict mortality.

F Leclerc, S Leteurtre, O Noizet, A Dorkenoo, A Sadik, R Cremer, C Fourrier
Paediatric Intensive Care Unit, University Hospital of Lille, Lille, France
Correspondence to: Professor Leclerc, Hôpital Jeanne de Flandre, 59037, Lille, France; leclerc@chu-lille.fr
higher number of cases were reported from rural regions as compared to metropolitan areas strongly suggesting either misdiagnosis or inaccurate recording of cases in the emergency department log of busy hospitals. A second concern is the reporting of cases only up to age 15. In the paper mentioned above, of 32 fatalities 10 occurred in youngsters up to age 15. An additional 10 occurred in adolescents aged 16 to 19. Why did MacDougall et al not include all adolescents? A third question must always be raised when fatal food anaphylaxis is studied. Is it not possible that cases of fatal asthma were actually initiated by unidentified allergic reactions to food? All authors in this field are likely to agree that the ultimate cause of death may be irreversible airway obstruction, and all will agree that poorly controlled asthma increases the risk of fatal anaphylactic reactions to food, but we would suggest that the trigger responsible for individual asthma fatalities is not always determined. What about fatalities that never reach the emergency department and are misclassified on death certificates as asthma fatalities? Individuals that die at home and are classified as asthma deaths are unlikely to be further investigated in either the US or the UK.

Fourthly, the authors’ definition of severity seems incomplete. Individuals with severe food reactions who self administer epinephrine often do not go to hospital, are less likely to have reactions that require hospitalisation or cause death, and often they do not report these reactions to their physicians unless specifically queried. Some survive the reaction without treatment, become convinced that the food is safe, and therefore do not seek medical advice for their allergy. We could argue that the possible progression of these episodes to near fatal or fatal reactions, but this is that they are frequently under reported. The fifth issue concerns the safe administration of epinephrine. We disagree about the risk to children of the administration of a single dose of epinephrine as opposed to withholding that dose. We have no disagreement about aggressive treatment of asthma concurrently, and in fact we think that point should be emphasised. However families reading this commentary may become more fearful, than they currently are, about administering epinephrine. We know that epinephrine is not always life saving even when administered in a timely fashion, however withholding it surely must increase the risk of death. Over dosage certainly may occur, but it seems more likely that an overdose would be administered by medically trained personnel than by parents. The over prescription of epinephrine is a debatable issue, however it seems a small price to pay, with a low risk, in order to save even one young life.

Finally, we are very concerned that families will interpret this paper to mean that death from food allergy is very unlikely to occur and therefore they may relax their vigilance. If families of younger children become less concerned when their children become adolescents it may be difficult to institute a good prevention education program. This is supported by the opposite of the goal of education programs in the US (The Food Allergy and Anaphylaxis Network, www.foodallergy.org) and UK (The Anaphylaxis Campaign) aimed at making individuals with food allergy and the general population more aware of the problem and the potential for mortality. It is truly unfortunate that we cannot accurately identify all of the individuals who die during allergic reactions to food and use this information to do a better job of preventing these tragedies. We must continue our campaigns of education of medical professionals and the public, and we must be certain that emergency treatment is available when and where it is needed.

J O’B Hourihane Wellcome Trust Clinical Research Facility, Southampton University Hospitals NHS Trust, Southampton, UK

D Reading The Anaphylaxis Campaign, PO Box 275, Farnborough, Hampshire, UK

P Smith Brisbane, Australia

G Lock St Mary’s Hospital, London, UK

D Hill Department of Allergy, Children’s Allergy Centre, Royal Children’s Hospital, Parkville, VIC 3052, Australia

A Munoz-Furlong The Food Allergy & Anaphylaxis Network, 10400 Eaton Place, Fairfax, VA 22030, USA

S A Bock National Jewish Medical and Research Center, Department of Paediatrics, University of Colorado Health Sciences Center, Denver, CO, USA

Correspondence to Dr Bock; Bockdoc@aol.com

References
1 MacDougall CF, Cant AJ, Colver AF. How dangerous is food allergy in childhood? The incidence of severe and fatal allergic reactions in the UK and Ireland. Arch Dis Child 2002;86:2236–9

Authors’ reply

We thank Bock et al for their interest in our article. We respect their views on the interpretation of the data but it is of course for each reader to come to their own opinion on these. We would like to respond to their comments on the accuracy and validity of our data.

Did our paper under ascertain deaths? Bock et al base their concerns on our methods of case ascertainment and on comparison with another study. We cannot be certain about this but as the text indicated we used many sources and spoke to many experts in the field. We agree we did not search local newspapers but this would have been almost impossible as few were on CD-ROM in the 1990s. As mentioned, we did search national newspapers and all cases we came across were already known through one of our other sources. Finally, since publication, no-one has told us of a case we appear to have missed.

We specifically studied children up to 15 years because this is the group we were interested in. Many recommendations on risks to children are based on inferences from data covering all ages and we wanted to bring a proper paediatric perspective. Indeed the interpretation Bock et al give to the paper they cite is grossly misleading. They suggest extrapolation to a US population would lead to 200 deaths from food each year. Yet the paper, in which there is only one death (occurring during exercise), covers all ages and reactions to all allergens, not just food.

The issue of whether asthma deaths may have been precipitated by food is an important question which we addressed “If a child’s symptoms are only asthmatic and no allergen is suspected, then there is no means for attributing such reactions to food or for knowing if a causal link exists”. Furthermore, such deaths will never have been reported in surveys of food allergy in other countries or in other age groups. No group has been able to address this question satisfactorily and it is a key area for further research.

We are not sure we agree that children, who have self administered epinephrine, often do not go to hospital. However we do not know the proportion and said as much, excluding this group from our definition of severity.

Finally we agree that education of professionals and the public should continue based on the best data available. This include those parents whose children are truly at high risk as well as those many parents that think any immediate hypersensitivity reaction to food means their child is at high risk of an allergic death; when in reality the risk, in the absence of asthma, seems very small. Different parents will come to different views about how to proceed faced by a severe but very small risk, just as we all do in many aspects of our lives.

A Colver Northumbria Health Care Trust and University of Newcastle upon Tyne, Donald Court House, 13 Walker Terrace, Gateshead NE8 1EB, UK

C MacDougall Newcastle General Hospital, Westgate Road, Newcastle upon Tyne NE4 6BE, UK

A Cant Paediatric Immunology and Infectious Diseases Unit, Newcastle General Hospital, UK

Correspondence to Dr Colver; allan.colver@ncl.ac.uk

Reference

Physiologic management of DKA

Inward and Chambers provide a provocative description and discussion of the continuing confusion regarding the issues surrounding rehydration and treatment of the pediatric patient with diabetic ketoacidosis (DKA). They review some of the key issues that link fluid therapy to complications from brain swelling, and question the appropriateness of using a volume of fluid calculated by “maintenance plus deficit”, calling for a second revolution in the management of DKA. In the accompanying commentary, Edge makes several statements concerning fluid therapy in DKA, including that “DKA is associated with severe fluid losses”, that “any guidelines for fluid and electrolyte management must be simple to calculate”, that administration of base is a risk factor for renal complications, and that despite published guidelines and “changes in protocols”, there is no evidence that the “incidence of cerebral oedema has changed over the past 20 years”.

It is our opinion that the problem in the rehydration of the pediatric patient with DKA...
The degree of dehydration ranges from negligible (<1 %) to extreme (>20 %). Severe ketoacidemia, however, does cause vasoconstriction which may be manifested peripherally by cool, mottled skin, and Kussmaul’s breathing which leads to undue dryness of the oral mucosa. The striking appearance of a parched mouth and the presence of cool, even mottled skin without a critical assessment of vital signs and examination of distal (foot) pulses often results in an erroneous impression of shock and “severe dehydration.” A method for estimation of the volume of deficit was described in 1990 and we continue to use this approach primarily. Successful therapy requires not only gradual deficit replacement (evenly over 48 hours) but an accurate estimation of the volume of deficit along with correction of the clinical and biochemical response. If the deficit is assumed to be 10–15% but is actually only 3%, that patient will receive excess water independent of the more gradual timeframe and independent of the individual assessment of the degree of deficit. Overestimation will overlie the mild to moderately dehydrated child; the problem is compounded when actual body weight is used instead of ideal body weight in fluids administered to the patient. On the other hand, certain patients, particularly those with compounding illness—for example, septic shock, pancreatitis—may require more than 20 ml/kg of fluid resuscitation in the first treatment hour and more than 50 ml/kg in the first four hours. Setting arbitrary fluid volume limits per hour or per day endanger particu-
larly those patients at the mild and severe ends of the dehydration spectrum. Although the insult would be greater with hypotonic fluid, overhydration occurs readily with isotonic fluid as well when water requirements are overestimated.

DKA represents the effects of a complex disruption of normal metabolism, which leads to metabolic death if left untreated. Shock (decreased peripheral pulses, with or without hypotension), if present, should be corrected rapidly. Insulin should be given preferably by continuous, low dose, intravenous infusion, as soon as possible to begin correction of ketoacidemia/ketoacidosis. Regardless of the serum concentration of glucose, insulin is required to correct the hepatic fat and acetylcarnitine cycle leading to ketoacid formation. A delay in insulin administration only serves to enhance and prolong ketoacidemia, thereby extending the period of time to the patient’s admission. Guidelines that have proposed “safe” limits to fluid volumes administered such as 4 litres/m²/day or 50 kg body weight/4 hours violate the concept of the individualised assessment of the degree of deficit, which invariably will overlie the mild to moderately dehydrated child; the problem is compounded when actual body weight is used instead of ideal body weight in fluids administered to the patient. On the other hand, certain patients, particularly those with compounding illness—for example, septic shock, pancreatitis—may require more than 20 ml/kg of fluid resuscitation in the first treatment hour and more than 50 ml/kg in the first four hours. Setting arbitrary fluid volume limits per hour or per day endanger particularly those patients at the mild and severe ends of the dehydration spectrum. Although the insult would be greater with hypotonic fluid, overhydration occurs readily with isotonic fluid as well when water requirements are overestimated.

DKA represents the effects of a complex disruption of normal metabolism, which leads to metabolic death if left untreated. Shock (decreased peripheral pulses, with or without hypotension), if present, should be corrected rapidly. Insulin should be given preferably by continuous, low dose, intravenous infusion, as soon as possible to begin correction of ketoacidemia/ketoacidosis. Regardless of the serum concentration of glucose, insulin is required to correct the hepatic fat and acetylcarnitine cycle leading to ketoacid formation. A delay in insulin administration only serves to enhance and prolong ketoacidemia, thereby extending the period of time to the patient’s admission. Guidelines that have proposed “safe” limits to fluid volumes administered such as 4 litres/m²/day or 50 kg body weight/4 hours violate the concept of the individualised assessment of the degree of deficit, which invariably will overlie the mild to moderately dehydrated child; the problem is compounded when actual body weight is used instead of ideal body weight in fluids administered to the patient. On the other hand, certain patients, particularly those with compounding illness—for example, septic shock, pancreatitis—may require more than 20 ml/kg of fluid resuscitation in the first treatment hour and more than 50 ml/kg in the first four hours. Setting arbitrary fluid volume limits per hour or per day endanger particularly those patients at the mild and severe ends of the dehydration spectrum. Although the insult would be greater with hypotonic fluid, overhydration occurs readily with isotonic fluid as well when water requirements are overestimated.

DKA represents the effects of a complex disruption of normal metabolism, which leads to metabolic death if left untreated. Shock (decreased peripheral pulses, with or without hypotension), if present, should be corrected rapidly. Insulin should be given preferably by continuous, low dose, intravenous infusion, as soon as possible to begin correction of ketoacidemia/ketoacidosis. Regardless of the serum concentration of glucose, insulin is required to correct the hepatic fat and acetylcarnitine cycle leading to ketoacid formation. A delay in insulin administration only serves to enhance and prolong ketoacidemia, thereby extending the period of time to the patient’s admission. Guidelines that have proposed “safe” limits to fluid volumes administered such as 4 litres/m²/day or 50 kg body weight/4 hours violate the concept of the individualised assessment of the degree of deficit, which invariably will overlie the mild to moderately dehydrated child; the problem is compounded when actual body weight is used instead of ideal body weight in fluids administered to the patient. On the other hand, certain patients, particularly those with compounding illness—for example, septic shock, pancreatitis—may require more than 20 ml/kg of fluid resuscitation in the first treatment hour and more than 50 ml/kg in the first four hours. Setting arbitrary fluid volume limits per hour or per day endanger particularly those patients at the mild and severe ends of the dehydration spectrum. Although the insult would be greater with hypotonic fluid, overhydration occurs readily with isotonic fluid as well when water requirements are overestimated.

DKA represents the effects of a complex disruption of normal metabolism, which leads to metabolic death if left untreated. Shock (decreased peripheral pulses, with or without hypotension), if present, should be corrected rapidly. Insulin should be given preferably by continuous, low dose, intravenous infusion, as soon as possible to begin correction of ketoacidemia/ketoacidosis. Regardless of the serum concentration of glucose, insulin is required to correct the hepatic fat and acetylcarnitine cycle leading to ketoacid formation. A delay in insulin administration only serves to enhance and prolong ketoacidemia, thereby extending the period of time to the patient’s admission. Guidelines that have proposed “safe” limits to fluid volumes administered such as 4 litres/m²/day or 50 kg body weight/4 hours violate the concept of the individualised assessment of the degree of deficit, which invariably will overlie the mild to moderately dehydrated child; the problem is compounded when actual body weight is used instead of ideal body weight in fluids administered to the patient. On the other hand, certain patients, particularly those with compounding illness—for example, septic shock, pancreatitis—may require more than 20 ml/kg of fluid resuscitation in the first treatment hour and more than 50 ml/kg in the first four hours. Setting arbitrary fluid volume limits per hour or per day endanger particularly those patients at the mild and severe ends of the dehydration spectrum. Although the insult would be greater with hypotonic fluid, overhydration occurs readily with isotonic fluid as well when water requirements are overestimated.
justifies a recommendation for the use of the longer needle for immunisation in 4 month old infants.

We believe the non-significant difference in tenderness with the different needles must be interpreted with caution, and should not be taken as a rationale for ignoring the significant benefits in terms of reduced redness and swelling. Tenderness was in fact reduced by the same relative amount as redness, but as tenderness occurred less frequently, the results were not formally statistically significant. We have used Bayesian analyses (using an “uninformative” prior distribution) to formally compute the chance that there is a clinically significant reduction (of at least 25% as specified in the protocol) in tenderness between the long and short needles. At six hours the probability of a clinically significant decrease in tenderness with the longer needle is 73%, whereas the chance of a clinically significant increase is only 2%. The evidence is therefore clearly in the direction of the longer needle causing less harm.

We recognise the need for further evidence on which to base immunisation practice at each of the infant immunisation ages. To this end, we are now conducting a randomised controlled trial involving over 600 infants aimed at providing a definitive answer. In the meantime, we reiterate our recommendation to practitioners to use the longer needle for immunising 4 month old infants.

L Diggle
Oxford Vaccine Group, Department of Paediatrics,
University of Oxford, John Radcliffe Hospital,
Oxford OX3 9DU, UK

J Deeks
Centre for Statistics in Medicine, Institute of Health Sciences, University of Oxford, Oxford OX3 7LF, UK

Correspondence to: L Diggle; linda.diggle@paediatrics.ox.ac.uk

Reference