ALTE and gastro-oesophageal reflux

McGovern and Smith’ve embarked on the welcome development of an evidence based algorithm for the investigation of infants presenting with an apparent life threatening event (ALTE). Unfortunately, they do not distinguish between coincidence and causality. Recurrent vomiting occurs in over 60% of 4 month old babies,’ and it is therefore unsurprising that gastro-oesophageal reflux is commonly found in infants presenting with ALTEs. The aim of their study was to determine the diagnoses reported after the first evaluation of an ALTE, but the paper’s title then somewhat misleadingly refers to “causes” of ALTE.

Despite the fact that in six of the eight studies analysed, patients did not routinely undergo pH monitoring, one of the most common diagnoses made was “gastro-oesophageal reflux disease” (GOR). This begs the question as to whether most if not all of the children merely had physiological gastro-oesophageal reflux (GOR), wrongly defined as GORD, simply because of the ALTE under investigation—an unwarranted assumption of causality. Moreover, they fail to point out that the milk scans and contrast studies used in some of their cited studies have unacceptably low sensitivity and specificity in the diagnosis of non-physiological GOR.

Their suggested plan of investigation acknowledges that in around 50% of infants experiencing an ALTE, a careful history and examination will point to an underlying diagnosis. Conversely, in the absence of other symptoms (for example, vomiting) they imply it may be important to identify and treat occult reflux by recommending investigating for GORD. Demonstration of a significant temporal relation between lower oesophageal acidification and apnoea is crucial in establishing a causal hypothesis linking the two. However, when Arad-Cohen et al explored the relation between GORD and apnoea in infants with a history of ALTE during polygraphic recording, only 19% of 741 brief apnoeas were coupled with GORD, and of these, apnoea preceded rather than followed GORD in the vast majority. The concept of an “ALTE—sudden infant death” spectrum in which GORD plays an important role is no longer widely accepted.

We argue that there is no need to perform tests for GORD unless there is a suggestive clinical history such as vomiting during or after feeds, poor weight gain, feed refusal, etc. Under these circumstances pH monitoring (whatever its limitations) remains the investigation of choice. A reliance principally on contrast studies and clinical history is likely to mean that physiological “GOR” will be diagnosed as “GORD”. This may lead not only to unnecessary treatment, but also focus attention away from serious disorders including factitious illness. We regard pH monitoring in children who have experienced an ALTE but have no clinical pointers to GORD as being of little value, and contend that there is no evidence base for such an approach.

J W L Punts, I W Booth
The General Infirmary at Leeds, UK;
john.punts@leedsth.nhs.uk
Competing interests: none declared

References

Authors’ reply

We appreciate the thoughtful comments on our recent paper. The main points raised by Dr Punts and Booth are:

- Most of the studies in this review did not diagnose GORD by the accepted criteria
- The issue of causality was not addressed
- They recommend investigating for GORD only when there is corroborating clinical information because occult reflux does not cause apnoea.

We agree that the diagnosis of GORD disease requires a combination of clinical information and selective testing. We acknowledged in our paper that there were varying investigative protocols for this disease. We were unable to review the diagnostic criteria for all studies. This reflects the lack of one standardized well validated test. pH probes have limitations as well because they do not detect non-acid reflux. The clinicians in the studies reviewed reported GORD as a diagnosis after an ALTE, but did not say it caused the ALTE.

The issue of causality was clearly addressed in the discussion and we agree that it is a very important point for exactly the reasons which Drs Punts and Booth highlight. To repeat, we have said that the detection of a disorder after an ALTE does not necessarily mean that the two are associated. We noted that there was conflicting evidence as to whether or not the relation between GORD and ALTEs is causal. Even when an underlying disorder such as RSV infection (which seems to have a clear temporal relation with an ALTE) is detected, the question is still unresolved as to why some infants react to RSV infection with apnoea while others do not.

It is likely that several factors interact to produce an ALTE. We do not think the relation between GORD and apnoea has been clearly established in the medical literature. Drs Punts and Booth write that demonstration of a significant temporal relation between lower oesophageal acidification and apnoea is crucial in establishing a causal relation between the two. However, in an editorial review of GORD and infant apnoea, it is noted that GORD and apnoea may have a causal relation that is not necessarily temporal. Given the current state of conflicting evidence, it would seem reasonable to investigate the upper gastrointestinal tract according to our algorithm (see discussion below).

We agree that the paper could be titled “Diagnoses reported after apparent life threatening events in infants: a systematic review”. The abstract, however, summarised the aims, results, and conclusions of the review.

We have not advocated a blanket investigation for GORD in all ALTEs. We have designed our algorithm with several selection points. The algorithm indicates that if the patient does not have a short, self-correcting episode around feeding (often physiological GORD), then a period of observation (including a review of history and examination) is indicated. Then, if the history suggests GORD, appropriate testing is performed. This is no different from the approach suggested by Drs Punts and Booth. If no cause is forthcoming and the clinician is concerned about the event, we do recommend a series of investigations, which include investigation of the upper gastrointestinal tract. Perhaps the algorithm would be more accurately written as investigation of the upper gastrointestinal tract instead of investigating for gastro-oesophageal reflux to acknowledge the possibility that anatomical abnormalities of the gastrointestinal tract may present with an ALTE.

The problem of ALTEs is one faced daily by front line clinicians. The purpose of our review was to try to bring some clarity and order to conflicting literature. We view this paper as a starting point for an evidence based approach. We invite further discussion.

M B H Smith, M C McGovern
Craigavon Area Hospital, Northern Ireland, UK;
msmithcal@cht.ni-nhs.uk
Competing interests: none declared

Reference

Diagnosis of iron deficiency anaemia

According to Wright et al, taken in isolation, a mean cell haemoglobin (MCH) of <25 pg is
more likely to predict a significant haematological response to a trial of iron replacement therapy than a mean cell volume (MCV) of <75 fl, on its own. My own approach to identifying which of the two red blood cell indices, namely MCH and MCV, was the stronger predictor of iron deficiency was to evaluate the cut-off levels which yielded the optimum combination of sensitivity, specificity, and positive predictive value for unequivocal iron deficiency, the latter being defined as a serum ferritin of <10μg/L. In a study comprising 365 adults characterised by an MCH of <26pg and/or an MCV <80 fl, 145 of whom proved to be unequivocally iron deficient, an MCH of <24 pg was identified as being the one associated with the optimum combination of sensitivity (74%), specificity (59%), and positive predictive value (80%) for this diagnosis. Correspondingly, an MCV <76 fl was the one associated with the optimum combination of sensitivity (65%), specificity (66%), and positive predictive value (55%). Fortuitously, in the ABC of clinical haematology, it is also an MCV of <76 fl which is utilised in what I would describe as “automated” screening for iron deficiency.

However, what has not been addressed until very recently, is the issue, not only of the supervision of MCH in predicting a favourable response to a therapeutic trial of iron replacement therapy, but also its robustness, relative to the MCV, under laboratory conditions of automated screening. According to one of the leading authorities on the subject, different counting systems yield “clinically significant different” estimates of the MCV, as shown by the monthly reports of the UK General Haematology NEQAS Scheme. In contrast, MCH yielded a “consistent equality of results reported by the different technologies within the UK NEQAS schemes”.

These observations tend to support the suggestion made by the authors of the present study that, as opposed to the MCV, the MCH should be the preferred screening test for predicting a satisfactory haematological response to iron replacement therapy.

O M Jolobe
Retired Geriatrician

Correspondence to: Dr O M Jolobe, Manchester Medical Society, 1 The Lodge, 842 Wilmslow Road, Didsbury, Manchester M20 28N, UK; oscarjolobe@yahoo.co.uk

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References


Replacing mercury sphygmomanometer in paediatric clinical practice: is there a need for a consensus conference?

The definition of normal blood pressure (BP) values in adolescents and children is based on mercury sphygmomanometry, and standard mercury readings are the main basis for BP-disease associations. Unfortunately, mercury has toxic effects on the environment and the mercury sphygmomanometer will have to be gradually replaced. However, there is a rearguard movement to retain mercury until some satisfactory substitute can be found.

We investigated the type of BP devices that are currently being used in Departments of Paediatrics in Greece. In a total of 76 departments, 30% use a mercury sphygmomanometer, 25% use automated devices, 25% use either mercury or automated devices, and 20% use an aneroid sphygmomanometer. Interestingly, 1 in 3 departments has the commonly used automated monitor “Dinamap” (several models); furthermore, half of these departments are using the model 8100. However, the accuracy of Dinamap monitors is questionable, especially the model 8100, which, when tested against the standard mercury sphygmomanometer, was found to detect mean systolic and diastolic BP values significantly above auscultatory readings.

We feel that replacement of mercury sphygmomanometer with automated devices has become increasingly common but, also, rather questionable in some countries, considering the lack of validated automated devices for the paediatric age group. The recent “International Protocol” established by the European Society of Hypertension for validation of BP measuring devices, is designed for adults and does not make recommendations for children. Facing the beginning of new standard in clinical sphygmomanometry, there is little doubt that we need a consensus conference. Such a conference would help in making recommendations for endorsing the use of alternative devices as the optimal replacement for mercury devices. In addition, the development of appropriate validation standards for paediatric use of BP devices and the elimination of inaccurate monitors would improve our methods of BP measurement and interpretation.

A. Attilakos, I Antoniadou
Department of Social Paediatrics, Institute of Child Health, Agia Sophia Children’s Hospital, 11527 Athens, Greece; attilakos@hotmail.com

Competing interests: none declared

References


Core paediatrics: a problem-solving approach

Core paediatrics presents this as “A boy with a croopy cough and breathlessness”. Other examples are “A child with a black eye”, “A tired teenager”, and so on...

The authors present each chapter in a systematic manner. A clinical case is presented—many of which the typical student is likely to encounter on any paediatric attachment. Realistic differential diagnoses are then presented, the same way in which a junior doctor may formulate impressions after clerking such a child. The authors then go on to consider each of the differential diagnoses at length, taking into account aetiology, pathology, investigations, and management. Frequently, the text pauses to present the reader with “Self-tests”. These questions are relevant to the clinical case and many are typical dilemmas that doctors face in planning management for unwell children. Some are presented as extended matching multiple choice type questions.

The authors stress the importance throughout, of history and examination, and guide the reader in elicitng key facts in the clinical cases. Throughout the book, information is presented in easy to read tables and diagrams, which appeal and break up the text. Relevant investigations are discussed at length, often with illustrations. Dilemmas are often centred around such investigations—for instance, how should a urine sample be obtained from young children when investigating UTI? Further questions relate to interpretation of such investigations—ensuring a clinically relevant approach. Throughout the text, misleading “normal” test results are discussed as well as obvious positive test results. Management of various conditions is presented in a structured way, incorporating both immediate and long term issues. When relevant, drug doses are included—useful for junior doctors, as well as other tips such as writing child protection medical reports. The book progresses through management of cases, presenting likely progress that a child may make
Core paediatrics therefore is primarily aimed at medical students. It approaches paediatrics in a manner that a student is likely to understand well and encounter on an attachment. It moves away from a traditional system based approach, towards a clinical presentation based approach, while integrating basic science and pathology of each disease well. The text is also likely to be appealing to junior doctors embarking on a paediatric career who require refreshment of how children present when ill. The 40 presentations of unwell children that the book describes are likely to incorporate many such patients who will present to a department.

J L Phillips

Chief complaints in pediatrics

Edited by Theodore C. Sectish. Pocket Medicine, 2002. US$50.00. Buy from: http://www.skyscape.com. Memory requirements: for palm 0.4 MB, for Pocket PC 0.8 MB.

Have you ever wondered, looking at Wisteria, if the plant in front of you is right or left winded? Do you know how to tell? Once you know, it is easy. It is just the same with this publication. This is not a book, not even an eBook. Chief complaints in pediatrics is software. It is worth clarifying this right at the start, as there are some practical consequences to this. After installation you will find its icon in the list of programs. If you simply follow the prompts, it will install itself to the main memory. If you then realise that you want to have it on your memory card you will have to go through uninstall and install (to the chosen location) procedure. As this is not a book, there are no numbered pages.

The interface is easy and intuitive, you will be able to do it all without looking into Help. The same unified interface can be found on all Skyscape products; if you have used Archimedes, a popular free program that medical professionals on traditional medical books with text and few illustrations. It will prove to be long term disadvantages compared with the web based approach. It is worth remembering that, while multimedia is useful, it is not a substitute for the "real thing". The clinical experience engages the whole brain at sensory, intellectual, cerebellar, and emotional levels. We are still far from virtual reality here, but this resource is certainly an advance on a traditional textbook with text and few illustrations.

E Posner

Pediciatric physical diagnosis electronic atlas


Today, medical education faces huge challenges. The patient contact time essential for developing clinical acumen has been progressively eroded by increased trainee numbers, reduced working time, reduced training duration, shifts, and encroachment of non-medical professionals into additional medical areas. Skills labs have evolved to cover basic skill sequences, but there remains a gap between core skills and clinical practice. An obvious approach is to "can the experience" and use modern technology to bridge the hiatus, ensuring some exposure at least to core conditions. There are various ways of developing such collections: the proprietary way, as here, or by using the internet, as for example at www.brishto.ac.uk/bbh, www.hon.ch/HONmedia, www.healthcentral.org, or www.peir.org.

This single DVD comes in a large glossy box with significant dead space. The authors are American, mainly from the Children's Hospital of Pittsburgh. The resource consists of "over 2500 visual representations of a broad range of common and uncommon pediatric disorders". There are over 40 video and audio clips too. The images can be saved to a separate area (like a shopping trolley on the web), then transferred to PowerPoint. The video and audio can be navigated to on the disc and transferred using cut-and-paste. The license does not allow materials to be integrated into other teaching resources (for example, question banks), nor can the PowerPoint presentations be placed on the web or intranet. Images can be viewed without audio annotations, but there is no interactive self-assessment (that is, scoring or review of wrong answers).

The term "physical diagnosis" is used broadly, and is not restricted to clinical signs. For example, x ray pictures, blood films, karyotypes, and diagrams are all included. It also includes many medical children, for example in the section on child development. The resource quality is generally good to excellent, with most images presented as full colour JPS. The highlights for me were the video clips of different forms of epilepsy. These bring to life an otherwise difficult topic. I was a little disappointed with the quality of some of the heart sounds. Coverage is inevitably incomplete: for example, there were excellent radiographs of pneumocystis, mycoplasma, and tuberculous pneumonias, but none of typical lobar pneumonias or bronchiolitis.

Searching is rudimentary, either by one of 23 chapter headings and scrolling through the thumbnails or by using a simple search string (US spellings) through the annotations. There is no metadata, but audio/video files can be accessed separately using tabs. This means that there is a learning curve associated with using the resource effectively with the potential to miss media that are in it. With repeated use its value increases greatly.

It is an excellent and reasonably comprehensive resource for an auditory and visual resource. It may be available for teaching purposes, particularly those with slow or difficult internet access. A huge amount of work has gone into its production and the authors are to be congratulated. It provides a good way to learn most classical presentations for examination, particularly DCH and Part 2, though the text version may allow for a more structured approach. I shall certainly be using it for my own teaching. I suspect that the restrictions of DVD capacity, publishing cycle (versioning), searching, and copyright will prove to be long term disadvantages compared with the web based approach. It is...
Jim Gage is a master in the use of automated gait analysis to rationalise surgical decision making for children with walking disorders, and, with his wealth of experience, accumulated over more than 20 years, he is a very appropriate editor for this volume. The clarity of his own thought processes is evident in his explanation of biomechanical principles applied to the complex dynamic gait problems encountered in children with cerebral palsy. A particular highlight is his chapter on the biomechanics of normal gait. His fellow contributors are all acknowledged experts in their own fields and complement his contributions well.

The main focus is the correction of problems with gait and the text illustrates how gait analysis can provide clear insight into the safety and efficacy of potential surgical intervention. The book is divided into five sections. Early chapters cover the neuroanatomical, neurophysiological, and biomechanical background; further sections are devoted to patient assessment, gait pathology, and treatment options including detailed discussion of orthopaedic surgery, and assessment of outcome. The role of the multi-disciplinary team is emphasised. The kinematics and kinetics of gait together with biomechanical modelling are covered in detail (and here the reader may just start to feel a little insecure in his knowledge of mathematics!).

The chapters on treatment demonstrate the logical differentiations between the primary, fixed problem—that is, the neurological injury itself; the secondary biomechanical problems, resulting from abnormal growth forces, which are amenable to treatment; and the tertiary compensatory problems which do not require treatment per se. Patterns of gait pathology are discussed with specific attention to hemiplegia, quadriplegia, and crouch gait, and the respective surgical solutions. Illustrative case studies are included and the data on the CD-ROM facilitates correlation between the clinical picture and the kinematic plots. The treatment role of selective dorsal rhizotomy is carefully delineated. One chapter is devoted to non-operative treatment modalities including botulinum toxin and intrathecal baclofen. Perhaps the section on botulinum toxin has emerged in the light of its increasing popularity as a first line treatment for reduction of dynamic spasticity—i was a little disappointed that it received only a passing mention in the treatment of upper limb deformities in hemiplegia, although there was more discussion of its use in the lower limb.

Although not all of us have access to a gait laboratory—and indeed it would not be appropriate to project all our patients with gait disorders to complex gait analysis—clinical gait analysis is readily performed in most centres treating children with spasticity. Basic biomechanical principles are equally valid across the spectrum of gait analysis, whether planning botulinum toxin injections or multi-level orthopaedic surgery. This book ably expounds these principles and illustrates their application to specific case studies, representative of all the most frequently encountered patient scenarios in clinical practice.

The biomechanical rationale for the proposed treatment is explained, and the results are demonstrated from follow up studies. As such, for the reader, this has a guide to refer to as he follows his own, sometimes uncharted, course. I suspect that I shall be dipping into it many times to refresh myself of the finer details as I manage the children in my own clinical practice.

I thoroughly recommend it to anyone with even a superficial interest in the field. Many times to refresh myself of the finer details as I manage the children in my own clinical practice.

R J Jefferson

Minor trauma in children, a pocket guide

For many paediatric doctors the emergency department (aka A&E) is only visited when referrals are made, or the crash bleep summons its screeching siren. These visits are usually straightforward, especially if the APLS creed can be chanted. However, for many of us who missed the emergency department in a rotation, the intricate management of minor cuts and bruises may evade us. Davies’s guide to minor trauma will help to glue the gaps in knowledge. From the initial child’s drawing on the front cover, there are a number of helpful illustrations, photographs, and x ray pictures that aid the guide and its reader. The presentation of the text leads your eyes through the various subheadings; important ideas are highlighted with the use of minia
ture road signs that are supposed to elicit an emergency stop.

The first few chapters set minor trauma in its context and explain the basics of management. Despite recent opposition to the use of such terminology, the reader is offered several interesting statistics on accidents and the outline of how strategies in society can prevent childhood injuries. Assessment and management is given its rightfully prominent position as the foundation for good holistic care of the child. An overview of general wound and soft tissue management follows before the guide leads the reader through chapters exploring various locations of the body. Each chapter carries a concise description of the various minor injuries that can affect the area, accompanied by useful x ray pictures; common causes; radiology and orthopaedic texts may now be circumvented.

More specific injuries such as minor burns are covered before reaching chapters that explore the difficulties of frontline medicine. Disorders of posture are a frequent feature of neurological disability. These often limit a child’s ability to function efficiently and sometimes circumvent the postural equipment described in this book) run courses using this volume as their reference material. The theoretical basis is very much that of a training manual, with multiple questions and activities targeted at the reader, and it was no surprise to learn that Active Design Ltd (the company who manufacture the postural equipment described in this book) run courses using this volume as their reference material. The theoretical basis that underpins the approach is concisely and clearly described in a series of chapters on the relevant aspects of biomechanics, neuromuscular, motor control, and motor learning theories. The book is well referenced and the text is supported by a number of excellent illustrations.

The management programme per se relies mainly on the 24 hour provision of postural

Disorders of posture are a frequent feature of neurological disability. These often limit a child’s ability to function efficiently and sometimes circumvent the postural equipment described in this book) run courses using this volume as their reference material. The theoretical basis is very much that of a training manual, with multiple questions and activities targeted at the reader, and it was no surprise to learn that Active Design Ltd (the company who manufacture the postural equipment described in this book) run courses using this volume as their reference material. The theoretical basis that underpins the approach is concisely and clearly described in a series of chapters on the relevant aspects of biomechanics, neuromuscular, motor control, and motor learning theories. The book is well referenced and the text is supported by a number of excellent illustrations.

The management programme per se relies mainly on the 24 hour provision of postural
equipment for lying, sitting, and standing. This may seem quite a heavy handed approach and one could question its tolerability in certain children. However its efficacy in reducing hip dislocation is already partly supported by a retrospective study, and further research is underway in a 5 year longitudinal prospective study at Chailey Heritage Clinical Services. I certainly look forward to reading their conclusions, and I hope they will feature in the book’s next edition as additional support to the approach.

Overall, working in the field of paediatric rehabilitation I found The Chailey approach to postural management a useful read and it did provide me with a better insight into the evaluation of postural disorders and their treatment. It gave me elements which will hopefully allow me to deal with these issues more confidently and fast. The fact that the strength of this book is that it offers a clear and coherent approach to what is a common problem in neurodisability. As such I would recommend it as an essential reference in all multidisciplinary centres that care for children with neurological impairments.

C J Newman

Cerebral palsy, principles and management


We devote time and energy, disproportionate to their numbers but not to their need, to these children. Diagnosis is often difficult, may be delayed, and the physical and psychological problems, intractable. There is an enormous and fast growing literature to help us, had we time to access it. A well organised, clear and concise introduction to the conditions which fall under the heading of cerebral palsy, and an update on management of its complications which come with it, would be welcome.

Unfortunately, Cerebral palsy, principles and management, does not fill the bill. As I read, I felt like a diver, struggling deeper into a hole. The description of form that made it impossible in all but a few chapters to shell out a pearl. I was unable to decipher the meaning of considerable portions of the book. There is undesirable grist—well—controversial advice regarding anticonvulsants, annual pertussis immunisation, and treatment of undes- cended testicles by hormone injection in preference to orchidopexy, to take three random examples. And any candidate for MRCPPCH who holds a baby upside down by one leg to test the Collis II reaction as depicted in the chapter on therapeutic concepts, is likely to fail. Another child on the same page appears to be being smothered beneath an ample bosom.

I cannot recommend this book.

M Wheeler

Management of the motor disorders of children with cerebral palsy, 2nd edition


There has been an interval of 20 years since publication of the first edition of this book, and this second edition reflects the progress in this field. David Scrutton has invited two colleagues, Dianne Damiano from the USA, and Margaret Mayston, originally from Australia to join him as editors, and together they have commissioned contributions from an international group of experts who reflect the current approach to care. The book is written primarily for therapists but there is much of value for paediatricians.

The introduction describes current treatment dilemmas. In the past, physiotherapy programmes were based on philosophies of care. Modern management is based on clinical principles with a scientific rationale for their use. Evidence for their efficacy is emerging but remains sparse.

The first chapter defines cerebral palsy and describes the various cerebral palsy syndromes, their correlation with MRI scan findings, and the concept of causal pathways. A wide range of descriptive terminology for cerebral palsy still exists which results in confusion, and more emphasis on areas of agreement would have been useful, such as that reached by collaboration between cerebral palsy registers.

The broad principles of care are well covered. Peter Rosenbaum has written an excellent chapter on the benefits of family centred care, involving the extended family such as grandparents. The evidence shows that this is associated with greater satisfac- tion for both care and care workers, and is most important for children with complex disability and multiple problems, where the risk of fragmentation of care is high. He then persuasively argues that develop- mental interventions need to be focused on promoting participation and achievement of functional goals, rather than fixing impair- ments. Eva Bower and Roslyn Boyd follow with helpful practical guidance to therapists on goal setting, models of assessment, and reliable tools to measure change or outcome. It is made clear that goals differ from aims, they should be specific and measurable, and relate to problems experienced by the child.

The second half of the book is devoted to therapeutic possibilities. At the cerebral level, some exciting possibilities are emerging based on neural plasticity in the damaged nervous system, such as constraint induced therapy. The reader is reminded that abnor- mal muscle tone is only one feature of the motor syndrome in cerebral palsy, and other aspects, such as muscle weakness, may be successfully treated with strengthening exercises. There has been an explosion of interest in new treatments for spasticity, such as intrathecal baclofen and focal injections with botulinum toxin. In controlled trials to date, functional gains have been limited and over- all muscle tone can be reduced by simple measures, such as relieving pain or ensuring a good night’s sleep.

The orthopaedic contribution emphasises the progressive nature of the musculoskeletal disorder in cerebral palsy and how this confuses families who learn that cerebral palsy is due to a static cerebral lesion. A biological clock is ticking and unrelied muscle spasm gradually leads to muscle shortening, bony torsion, joint instability, and ultimately degenerative arthritis. Appropriate management should have a limited influence the natural history. For example, monitoring of the hips in bilateral cerebral palsy with early intervention reduces the risk of dislocation and painful arthritis in adulthood. A chapter is devoted to the conservative management of deformity, using 24 hour postural care in conjunction with strategies to facilitate movement and function.

The wealth of alternative therapies and approaches to care, combined with a lack of hard evidence to promote one above the other, has been confusing for parents as well as professionals, and Margaret Mayston’s contribu- tion is helpful for both. She describes the various treatment approaches, ranging from the Bobath techniqueto all forms of complementary therapies such as hyperbaric oxygen, giving a balanced view of the available evidence as to their merits and disadvantages.

With the increasing lifespan of the most severely impaired young people, the impact on cerebral palsy in adults and should be essential reading for the paediatric team. There is evidence of a gradual loss of function and independence, aggravated by increasing weight and locomotor function. Adult care is at best fragmented, and a case is made for a coordinated service for adults
Paediatric oncology, 3rd edition

The first thing that struck me as a newcomer to this 3rd edition of Paediatric Oncology is the heavy alliteration of title and editors. The next was that exactly the book I have been looking for—both to have with me in the clinic and on the ward, and to dip into at night. It is a good size; heavy enough to promise sufficiently durable to be of real use and yet light enough to be carried in the hand. The paper is pleasingly thick, so that the print is easily legible, and both the black and white photographs and the colour plates are very clear. As a haematologist, I could have wished for a little more morphology, but overall the balance between picture and print is good. The layout makes the chapters readable, and even the sections which looked rather daunting with several columns were in practice simple to read.

The content is broken up into five parts: Scientific and diagnostic principles; Diagnosis and management of individual cancers; Advances in therapy: megatherapy; Advances in therapy: targeted therapy; and Late effects and supportive care. Each part is then divided into appropriate chapters. I particularly liked the use of boxes at the end of each chapter to recap key points. The reference lists are extensive and helpful in pointing to significant papers.

The text and the references have all been updated, and, given the length of time needed to get such a tome to press, are reasonably current. The list of contributors represents recognised experts in the various fields, and is drawn predominantly from the United Kingdom, making this a very relevant book for clinical practice here. However, I found myself concerned at a book on acute leukaemia a little disappointing. I felt the discussion rather overlooked the UKALL trials, concentrating instead on other protocols, and in particular the ALL-BFM trials—reflecting the author’s own experience. This is, of course, relevant and of interest, but, given that this is the most common childhood malignancy, and that this book is presumably aimed predominantly at a British audience, seemed to be a significant weakness.

This book is already a standard on the shelf of paediatric oncologists and haematologists. Would I recommend it for a general paediatrician or a haematologist working in a district general hospital? Yes, definitely. Is it worth upgrading from the last edition? Again, yes—for two reasons: firstly, this is a rapidly changing field, and the old edition is now out of date; and secondly, the quality of this edition, especially the photographs, makes it a delight to read.

S M Wallis

Pediatric orthopaedics and sports medicine, the requisites in pediatrics

This is the first of a series on paediatric sub-specialties.

My first impression of the book was that the content was daunting for a paediatrician. However, after reading selected chapters in detail, the authors certainly fulfilled their aim to educate paediatricians on how to approach an orthopaedic problem. My experience in paediatric training is that there is little exposure in managing musculoskeletal problems. The development of the musculoskeletal system in childhood and adolescence is a very important aspect of paediatrics and tends to be a neglected part of paediatric training. This book will help to rectify this.

There is substantial detail describing the mechanism and management of injuries. In fact, a patient of mine brought in her child who had fractured her radius and ulnar. She had consulted an orthopaedic surgeon but requested a second opinion from me. With the help of this book, which happened to be on my desk at the time, I was able to give an informed opinion on the appropriate management of this problem. I made no apologies about using the book!!

Sports medicine includes how the body adapts to exercise and the effects that exercise has on medical conditions such as asthma, diabetes, osteoporosis, malignancy, and other chronic disorders of childhood. Included in this, is the use of exercise in managing these conditions. Medical conditions were not included in this book. Thus a better title of the book would have been “Pediatric orthopaedics and sports medicine in childhood and adolescence”.

The book gave detailed accounts of overuse injuries involving anatomical sites. However, I felt that there could have been an introductory section describing, in principle, the unique types of injuries in childhood and adolescence.

A more detailed account of the rehabilitation of injuries, for example, the role of physiotherapy and biokinetics would have been helpful.

The chapters on paediatric rheumatology were clear, detailed, systematic, and moreover very easy to read.

The layout, tables, and photographs were excellent. The blocks summarising the salient points of each chapter were very useful. Above all, each section was well referenced.

This book is highly recommended to paediatricians and health professionals working with children.

R Leaver

Childhood epilepsy: language, learning and behavioural complications

Given that Alexander the Great, Julius Caesar, Cardinal Richelieu, and Lenin all suffered from epilepsy it is clear that epilepsy does not preclude future career success. The prominence of sufferers within the higher echelons of the creative arts is striking. Dostoevsky, Flaubert, Moliere, and Byron are just a handful of names that immediately spring to mind. Van Gogh’s most creative period coincided with the time when his epilepsy was at its worst. And yet, we know that epilepsy can have a dramatic and disastrous effect on the cognitive and language abilities of our paediatric patients. It is hard not to be moved by West’s description of how his son regressed following the development of infantile spasms. We hear similar stories time and again in paediatric clinics of how an apparently normal baby arrests developmentally and then regresses coincident with the onset of infantile seizures.

It must be equally distressing to be the parent of a child with Landau-Kleffner syndrome (LKS). One day you have a previously chatty 5 year old who suddenly is unable to understand what you are saying to them. Their speech and behaviour deteriorates and, to cap it all, they develop seizures.

We do not understand the relation between epilepsy and the cognitive, behavioural, and linguistic disorders so common in the other paediatric epilepsy syndromes. In both LKS and West’s syndrome they may have chaotic status-like electroencephalograms. We postulate that such chaos must be interfering the formation of critical neural synapses and pathways. However, the resolution of such electrographic disorder and clinical seizures may not, unfortunately, coincide with any cognitive or language improvement.

We search for effective treatments for these disorders. The breadth of different treatments used suggests that we are uncertain where to target our therapeutic approaches. For example, in LKS, steroids might improve the situation, but is it because they are modifying some infectious or autoimmune process or through their action at the GABA-A receptor? Indeed our treatments may exacerbate the situation. Virtually all the anticonvulsant drugs have been associated with behavioural and cognitive problems.

Of course, I am exaggerating the state of confusion in this area … but only slightly. I turned to Professor Svoboda’s book on the subject, looking for some clarity and direction. It is a veritable goldmine of anecdote and case reports. A lifetime of reading and clinical experience are condensed here. It would be wrong to say that this is an evidence-free area. Svoboda documents a wealth of studies, references, and data.
However, at the end of the book I longed for some critical appraisal of the evidence he had marshalled together. He gives no indication, for example, of the relative benefits of steroids, immunoglobulins, anticonvulsants, and sub-pial transection in the treatment of LKS.

In fact, this book is a testament to the lack of knowledge that exists. There is a pressing need for a good evidence base about the aetiology and treatment of these disorders. Which treatments improve cognitive outcome in infantile spasms? Is surgery preferable to medical therapy in LKS? Does treatment alter the prognosis of so-called benign focal epilepsies of childhood? The answers to such questions need to be unearthed but they are not to be found or hinted at in this book.

F J O’Callaghan

PediSuite 5.0


PediSuite is produced by Medical Wizards, a company founded in 2000 by a practising physician. The program is large and consists of 15 modules. Within each module there are numerous options. The selection of calculations, regimes and protocols is huge. Getting to know the content is time well spent as the information that you will be looking for you would usually want to know quickly.

This is software that aims to be a powerful calculator rather than an information source. Consequently, most of the modules contain some basic information about the topic but “the meat” of the program is numerous calculators that instantly work out dosages, speed of infusion, body mass index, croup score, etc for a given child. The interface is fairly intuitive and once you know what it contains no further guidance is required to be able to use it proficiently. There is one point where I stumbled and for some time thought that the program was freezing the PDA: within many modules you need to enter data about a child (usually weight) before you are allowed to access the content of the module. You also cannot exit these modules until you enter a number in the calculator. This is not a problem once you know it but I was just about to contact the Medical Wizards company when I cracked this.

In most of the modules the information is given in a cascade of windows. For example, within module PALS you choose “desired item”, let’s say bradycardia. The next window asks for the type of rhythm; from the options you choose “stable” and then the management of the problem pops up.

The modules include paediatric advanced life support (PALS) protocols, some basic paediatric data like normal vital signs values, laboratory results or immunisation schedules, a mini-poison centre, and growth charts. There are modules calculating various values relating to fluid balance and infusion rates, also for critical care infusions. Several extensive drug databases provide information about various groups of drugs (infection medication, sedation, emergency, etc). There is also a general index.

For the users on this side of Atlantic it has to be noted that PediSuite is an American product. In the PALS module, in case of asystole use of a “turkey baster” is recommended. In treatment of shock, you can give a push of “LR”. Some names of the drugs are not so familiar, many dosing regimes are different to those in mainstream UK use, and many investigation results are in different units. While it can complicate use of the information provided it also reminds us that there are many ways of skimming a cat (and surely many ways of basting a turkey?). I was glad to note that centimetres and kilograms can be used in the calculations.

It is difficult in brief words to convey how rich and versatile is the content of this software. I have spent hours playing with it and I have used it for several weeks at work. I still am not sure if an equation to calculate fractional sodium excretion is not there, or if I have simply not found it. A module “PediCalc” contains 14 different calculators. Some I thought unusual: “CHF and thrombolysis risk” or “oxygen tank routine”…

The more I used this software the more impressed I was, finding more and more useful tools. PediSuite is the most useful PDA program for a paediatric doctor I have come across. It is an extremely powerful tool for any paediatrician and it can be recommended at any stage of their career.

E Posner

Safeguards for young minds: young people and protective legislation, 2nd edn

Edited by Richard White, Anthony Harbour, Richard Williams, Gaskell (The Royal College of Psychiatrists), 2004, E15.00, pp 118. ISBN 1 904671 02 0

This book is invaluable for child psychiatrists, but not all paediatricians would be so attracted to it, except those who wish to understand the legal basis of child protection work. Those who might see it as irrelevant would be missing out on the combined rich experience of two paediatric solicitors and one child psychiatrist.

The chapter on consent is essential for all clinicians dealing with children, and has a superbly helpful flow diagram detailing how and when the child, young person, or parents can agree or refuse to medical or psychiatric assessment or treatment. The rules governing consent and refusal are surprisingly different. To my consternation, it leaves out all mention of assent, which I understand is a young person’s agreement to something that is legally sanctioned by others, and which I think is increasingly being sought in written form.

The best advice in the book is contained in one of the prefatory pages—consult a solicitor whenever in doubt. Don’t leave it until the issue is so contentious as to need deciding by the Courts. If you can develop a relationship with a legal adviser, this, the authors say, will be more valuable than any book. Although this may appear to be a free advert for solicitors, it is sound advice: your professional indemnity association and your Trust’s solicitors should already be paid for.

This is the second edition of a 1996 book that expanded on the authors’ condensation (in previous writings) of The Children Act 1989 to include related legislation. The new edition includes explanations for professionals dealing with children of The Human Rights Act 1998, The Children (Leaving Care) Act 2000, and The Mental Health Act 1983, revised in 1998 by a new Code of Practice. It will need further updating when and if the intended new Mental Health Act becomes law. The authors tread with great clarity through the confusing overlap of the Children Act and the existing Mental Health Act—which should be clarified by the new Act. They cover what you can and can’t do to children in hospital, and how age and the Gillick principle should affect clinicians’ decisions.

The book is written in commendably clear language, with a layout that encourages selective reading. If it has a significant fault, it is the lack of clinical details to flesh out the plentiful legal cases. It may seem to some like a primer for students of law, but it is in fact intended for, and essential for, practising clinicians.

Every department of child health should have a copy of this book, as well as every CAMHS service.

Q Spender